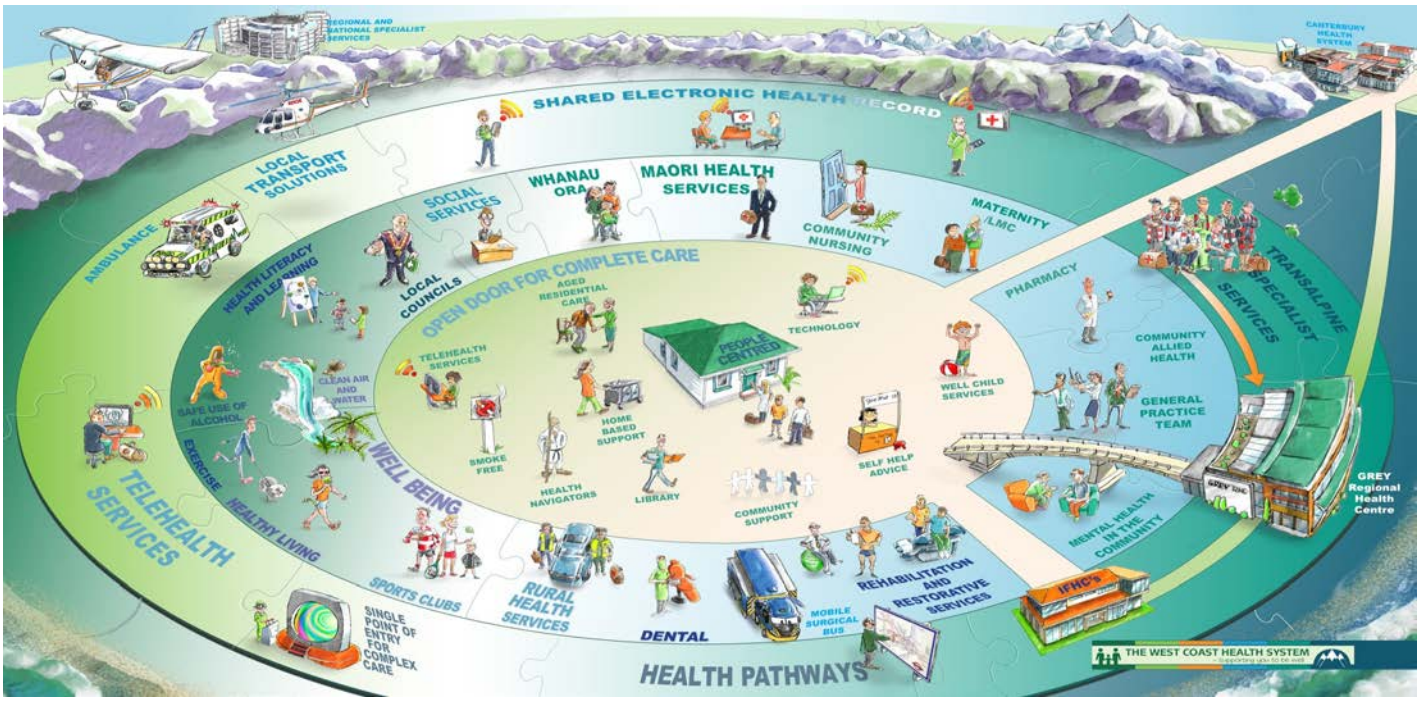
West Coast DHB Annual Report

for the year ended 30 June 2015



THE WEST COAST HEALTH SYSTEM

– supporting you to be well

TABLE OF CONTENTS

DIRECTORY	**2**
REPORT FROM THE CHAIR AND CHIEF EXECUTIVE	**3**
MEASURING OUR PROGRESS	**6**
ARE WE MAKING A DIFFERENCE?	**8**
STATEMENT OF SERVICE PERFORMANCE	**15**
MĀORI HEALTH ACTION PLAN PRIORITIES	**26**
BOARD'S REPORT & STATUTORY DISCLOSURE	**27**
STATUTORY INFORMATION	**34**
STATEMENT OF RESPONSIBILITY	**38**
STATEMENT OF COMPREHENSIVE REVENUE & EXPENSES	**39**
STATEMENT OF CHANGES IN Net assets/EQUITY	**40**
STATEMENT OF FINANCIAL POSITION	**41**
STATEMENT OF CASH FLOWS	**42**
NOTES TO THE FINANCIAL STATEMENTS	**43**
STATEMENT OF REVENUE AND EXPENDITURE BY OUTPUT CLASS	**72**
INDEPENDENT AUDITOR'S REPORT	**73**

DIRECTORY

Board Members
Peter Ballantyne, Chair
Kevin Brown
Helen Gillespie
Michelle Lomax
Peter Neame
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John Vaile
Susan Wallace

Chief Executive
David Meates

Registered Office
West Coast DHB
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Banker
Westpac Banking Corporation

REPORT FROM THE CHAIR AND CHIEF EXECUTIVE

The transformation of the West Coast health system has been underway for the past couple of years and over the 2014/15 financial year it has been exciting to see some of the fruits of our hard work. We are undertaking substantial work to create world-class rural health facilities that will provide exceptional and appropriate care.

Working collaboratively with the West Coast Primary Health Organisation (PHO), Community and Public Health, Poutini Waiora and general practices, the West Coast health system has become far more joined up in efforts to tackle the big health issues on the Coast.

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 revitalise 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

Expanding transalpine services

The West Coast's geography and relatively dispersed population has traditionally made the provision of health services challenging. Over the last 12 months we have continued to build relationships and invest in new technologies that have helped us improve the quality and variety of health services on the Coast.

Our transalpine partnership with Canterbury DHB evolved over the past year, with the range of services and specialists providing treatment and care to Coasters continuing to increase.

Our use of Telehealth in particular is continuing to improve access for West Coast people. Telehealth involves using information or communication technology to deliver health or medical care from a distance. On the West Coast it is helping remove the tyranny of distance by providing improved access to care. This has meant faster access to care, shorter wait times, and more convenient consultations.

Benefiting from technology

Telehealth is one of several technological platforms that are helping revolutionise the delivery of health services on the Coast.

The introduction of the HealthOne shared system for healthcare providers to access patient records, and the Safety 1st integrated online safety and risk reporting system within the past year are intrinsically linked to providing better, more consistent care for our people.

HealthOne went live in November. HealthOne is a secure data repository for electronic patient information made available through Health Connect South, the South Island's principal clinical information system. HealthOne provides West Coast GPs, pharmacists, community nurses and hospital clinicians with secure access to the latest patient information, enabling them to deliver better and safer care.

HealthPathways standardise how best practice care is provided to people on the Coast – regardless of where they enter the health system.

It's also great to see Safety 1st well embedded in both primary and secondary health arenas. The technology has made reporting easily accessible across the system.

Better Performance

The West Coast health system has improved its performance in most of the Government's health target categories. The performance improvements across the various targets have resulted from the health system working together on the areas that needed more focus.

In the emergency department target which requires 95% of patients to be admitted, discharged or transferred from an emergency department within six hours, the West Coast DHB continues to deliver against the national health target and in the final quarter of the year achieved an impressive 100% against the target.

The West Coast's elective surgery target is to deliver 1,592 surgeries during the year ending 30 June. The DHB exceeded the target by 8% delivering 1,721 elective surgeries.

West Coast DHB staff provided 98% of hospitalised smokers with smoking cessation advice and support - exceeding the 95% target with our best result yet.

Facilities update

The West Coast is getting much closer to the reality of a new healthcare facility in Greymouth, a facility the community can be proud of. The design facilitates a refined model of care, which the DHB has been progressing, enabling more flexible ways to utilise spaces to deliver integrated health services in an efficient way. The process to date has involved extensive engagement with a wide range of people including nurses, doctors, allied health professionals, our dedicated maintenance staff, administrators, managers and our Transalpine partners in Canterbury, to inform the design of the new facility.

The existing Grey Base Hospital will remain fully operational until completion of the new hospital and Integrated Family Health Centre, expected to be in March/April 2017.

There is ongoing progress with Buller's new Integrated Family Health Centre in Westport. A design team has been appointed, led by Warren and Mahoney Architects. This building design team will work closely with Buller clinicians on the next stage - the master plan and concept design.

Public consultation commenced on the way to provide targeted, integrated, high quality health services to ensure the wellbeing of Reefton's population.

Other highlights

- Lippincott Procedures have been introduced to standardise and improve evidence-based nursing practice. Lippincott Procedures provide access to step-by-step guides for more than 1,300 evidence-based procedures and skills in a variety of specialty settings online.

- The planned birthing service for pregnant women who are assessed as being low risk recommenced at the Kawatiri Birthing Unit.

- Extensive flooding of the Hokitika CBD resulted in the emergency evacuation of the residents and staff at Ultimate Care Allen Bryant. All 45 residents were successfully placed in DHB and private facilities in the Hokitika, Greymouth and Reefton area, or with families.

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

Peter Ballantyne
Chair
30 October 2015

David Meates
Chief Executive
30 October 2015

MEASURING OUR PROGRESS

How will we know we are making a difference?

DHBs are expected to deliver against the national health sector outcomes: '*All New Zealanders lead longer, healthier and more independent lives'* and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability, we need to demonstrate whether we are succeeding in meeting those commitments and in improving the health and wellbeing of our population. There is no single measure that can demonstrate the impact of the work we do, so we have chosen to use a mix of population health and service access indicators to demonstrate improvements in the health status of our population and the effectiveness of our health system.

In agreement with the other four South Island DHBs we have identified four collective long-term outcome goals, along with a set of associated outcomes indicators, which will demonstrate whether we are making a positive change in the health of our populations. As we expect to effect change against these indicators over the longer-term (up to 10 years in the life of the health system) the aim is for a measurable change in health status over time, rather than a fixed target.

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 acute medical admission rates.

Outcome 3: People with complex illnesses have improved health outcomes.

A reduction in avoidable mortality rates.

A reduction in acute readmission rates.

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

An increase in the proportion of the population living in their own homes.

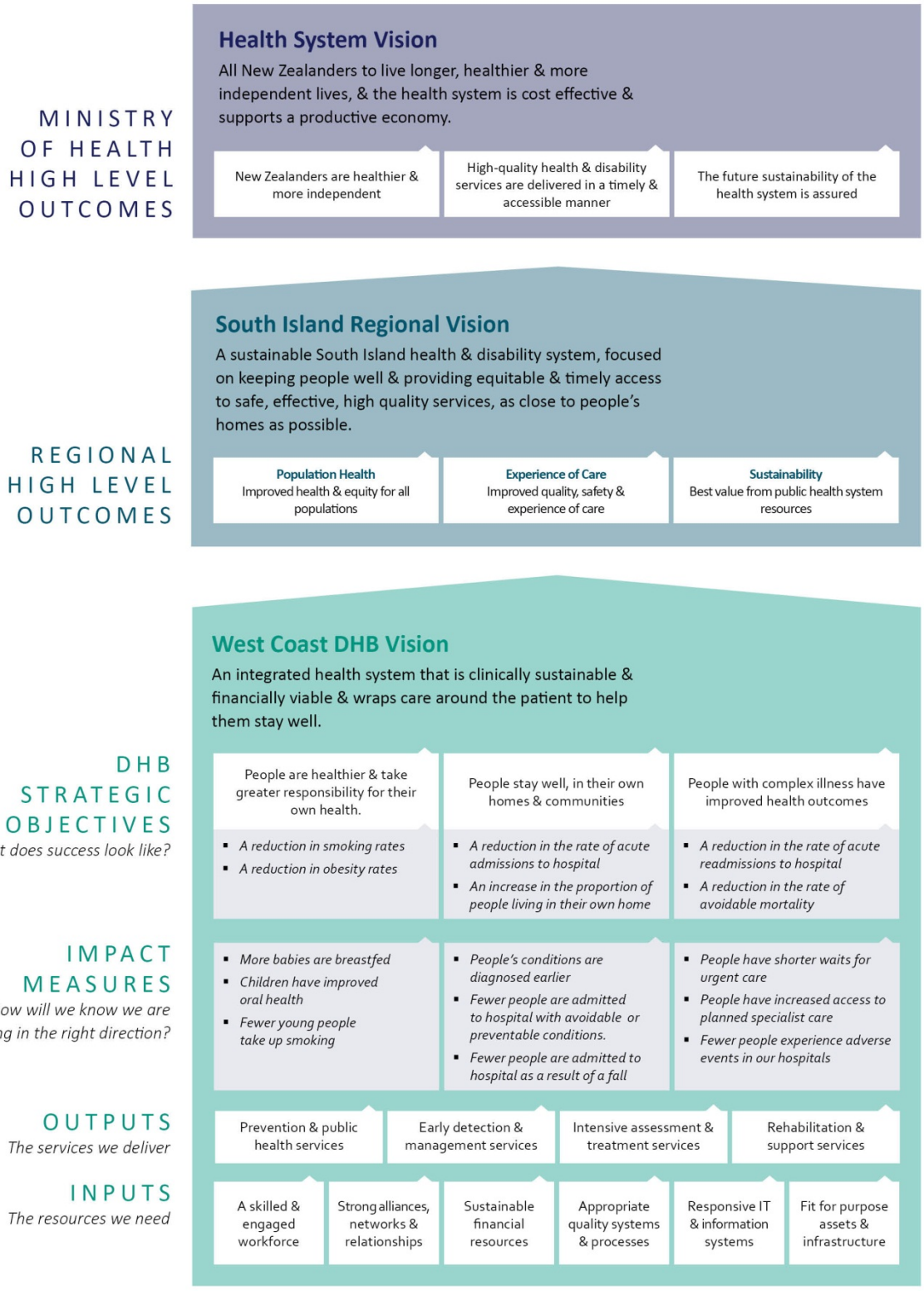
The five South Island DHBs have also identified a core set of associated set of medium-term impact indicators. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance. We have set targets against each of the impact measures to support the evaluation of our performance. Both the outcome and impact indicators sit alongside our Statement of Performance Expectations in our Annual Plan and are reported in our Annual Report at the end of every year.

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (*outputs*) will have an *impact* on the health of their population and result in the achievement of desired longer-term *outcomes* and the expectations and priorities of Government.

The DHB also has a Māori Health Action Plan which is a companion document to the Annual Plan and sets out a further set of performance indicators to support and identify improvements in Māori health outcomes. The 2014/15 Māori Health Action Plan is available on the West Coast DHB's website and performance against the key measures in the Action Plan are presented in this report.

Note: Small West Coast population numbers can have a disproportionate effect on the results for some measures and as such trends over time are often more relevant in determining performance rather than one year's result in isolation. Footnotes have been added to assist the reader where small numbers have a particular effect in terms of performance results.

Overarching intervention logic



ARE WE MAKING A DIFFERENCE?

Progress against these indicators suggests that the focus on improved service integration and patient flow between general practice and specialist services is beginning to deliver positive results in terms of the health of our population.

Smoking and obesity rates have dropped and both breastfeeding and oral health rates are showing slight improvements.

The West Coast continues to lead the country in achievement against the national shorter waits for emergency care health target and waiting times for specialist assessments and elective surgery have also reduced. Acute and avoidable hospital admissions, readmissions and premature mortality rates, while lifting slightly, all remain well below national trends.

In line with our strategic direction, the proportion of older people living in their own homes continues to increase as we support more people in the community. Performance is also positive in terms of reducing harm from falls both in the community and in our hospitals.

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

Why is this outcome a priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major drivers of poor health and account for a significant proportion of presentations across primary care and hospital and specialist services. Because we are more likely to develop long-term conditions as we age, and have an ageing population, the burden on our health system will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions. Long-term conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups. Supporting people to make healthy choices will not only enable our population to attain a higher quality of life by avoiding, delaying or reducing the impact of long-term conditions, but will also help to reduce the growing demand for health services.

OUTCOME MEASURES LONG TERM

Outcome: A reduction in smoking rates.

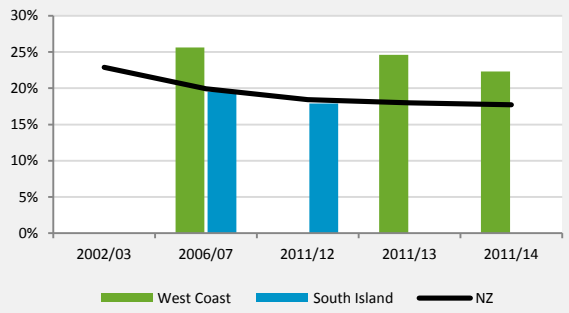
Smoking rates continue to decline, with the combined 2011/14 NZ Health Survey finding that 22% of the West Coast population smoke—compared to 26% six years ago.

Our success in continuing to reduce smoking rates can be attributed to two factors—fewer young people taking up smoking and more smokers being encouraged to quit.

Our focus on ABC quit initiatives remains strong with significant progress against the national primary care smoking target this year. Aukati Kaipaipa cessation registrations are also higher than ever before.

Data sourced from national NZ Health Survey.[1]

Measure: The percentage of the population (15+) who smoke.



Outcome: A reduction in obesity rates.

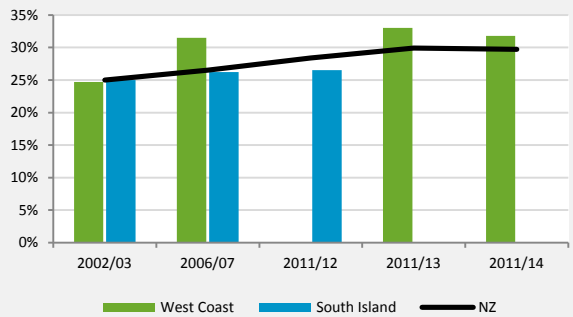
At 31.8%, West Coast's obesity rate remains just above the national rate of 29.7%. However an encouraging drop is evident between the two most recent surveys.

Lower rates of obesity are supported by local initiatives that encourage healthier diets and more physical activity, such as our Health Promoting Schools, Appetite for Life and Green Prescription programmes.

In the coming year the five South Island DHBs will implement a Child Obesity Action Plan, aimed at supporting positive attitudes and behaviours from a young age and creating a strong foundation for good health in adulthood.

Data sourced from national NZ Health Survey.[2]

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



[1] *The NZ Health Survey is completed by the Ministry of Health and results are subject to availability. From 2011, survey results were combined year-on-year in order to provide more robust results for smaller DHBs—hence the different time periods presented. Results are currently unavailable by ethnicity or region. The 2013 Census results for smoking (while not directly comparable) demonstrate that rates for Māori, while improving, are still high, with 34.3% of West Coast Māori (15+) being regular smokers, down from 41.4% in 2006.*

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

IMPACT MEASURES MEDIUM TERM

Impact: More babies are breastfed.

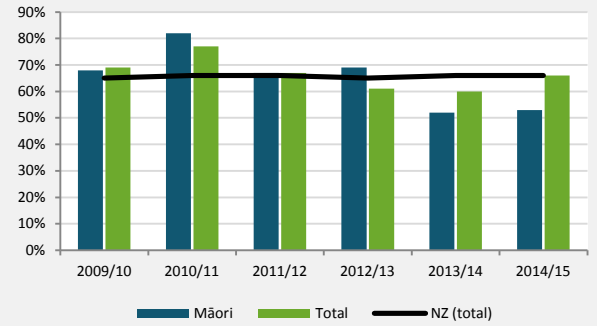
West Coast breastfeeding rates have lifted positively compared to the previous two years and are now on par with national results.

Māori results appear to have remained stable; however the data presented is from Plunket only and doesn't include small Tamariki Ora providers who target Māori mothers. It is likely that these results under-report Māori performance.

Improving breastfeeding rates continues to be a key focus for the cross sector Healthy West Coast Alliance Work Stream. A range of services are available to encourage and support women on the West Coast to breastfeed including peer support programmes and increased access to community based lactation support.

Data sourced from Plunket via the Ministry of Health.[3]

Measure: The percentage of babies exclusively or fully breastfed at 6 weeks.	13/14	Result 14/15	Target 14/15
Māori	52%	53%	74%
Total	60%	66%	74%



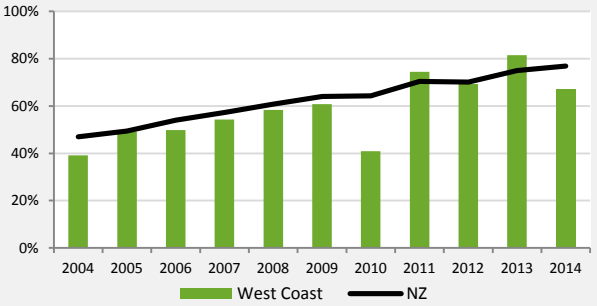
Impact: Fewer young people take up tobacco smoking.

The 2014 ASH survey results show a drop in performance compared with the previous year—however the survey numbers are small and subject to fluctuations between years. The overall trend against this measure remains positive.

This trend reflects the impact of supportive legislation and social environments combined with local initiatives such as our Health Promoting Schools programme, smokefree public places (such as parks and marae) and training and advice provided to tobacco retailers to limit youth access to tobacco. A continued decline in adult smoking rates will also have a positive influence on these rates.

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

Measure: The percentage of 'never smokers' among Year 10 students.	2012	2013	Result 14/15	Target 2014
	69%	82%	67%	75%



[3] *Provider data for breastfeeding is currently not able to be combined so performance data from Plunket (as the largest provider) is presented. While this covers the majority of mothers and babies, because the smaller local WellChild/Tamariki Ora providers target Māori and Pacific mothers—results for Māori are likely to be understated. The target is based on national Well Child standards for breastfeeding at 6 weeks.*

[4] *The ASH survey is a national survey used to monitor student smoking since 1999. Run by* Action on Smoking and Health*, it provides an annual point prevalence snapshot of students aged 14 or 15 years at the time of the survey. The average number of West Coast students participating in an annual survey is around 200-220 and this small numbers can lead to fluctuations between years —for more detail see www.ash.org.nz.*

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

Why is this outcome a priority?

When people are supported to stay well in the community and to access the care they need closer to home, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population by enabling early intervention but reduces the demand for specialist assessments and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke and achieve better health outcomes for lower cost than countries with systems that focus on a specialist level response.

OUTCOME MEASURES LONG TERM

Outcome: A reduction in acute medical admissions.

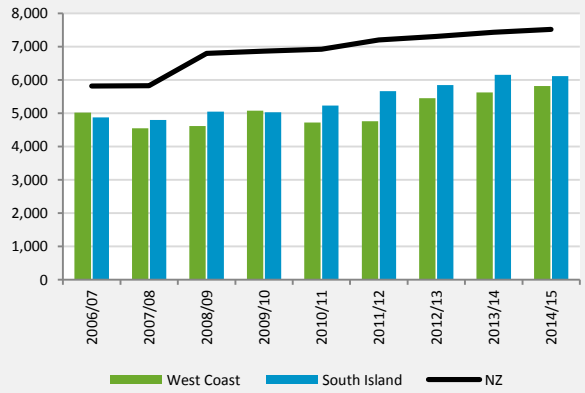
At 5,815 per 100,000 people, West Coast's standardised acute medical admission rate remains significantly below the national rate (7,516 per 100,000 people) and in 2014/15 was the third lowest in the country.

This is a positive reflection of the system-wide focus taken across the West Coast to keep people safe and well in their own homes and communities and out of hospital.

There are a number of local programmes specifically established to ensure people receive the right care at the right time. This includes our primary care led Long-term Conditions Management Programme which, by supporting people to better manage their own health, helps to prevent the need for acute care. Over 3,600 people were enrolled in the Programme in 2014/15.

Data sourced from National Minimum Data Set.

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



IMPACT MEASURES MEDIUM TERM

Impact: People access care when they need it.

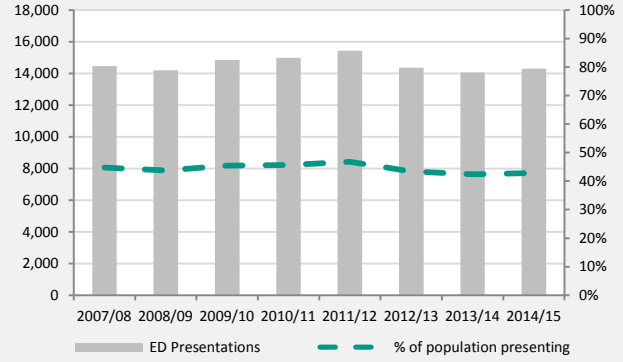
The percentage of the population presenting for urgent or emergency care has remained relatively static over the past several years.

While a stable result is positive the high proportion of people presenting in comparison to the DHB's lower acute and avoidable hospital admission rates suggests that many of these people do not require specialist level care and their needs could be better managed by extended or after hours general practice services.

The DHB is actively engaging with the PHO and general practice to identify opportunities for improving access to general practice after hours, with the aim of reducing this load in the coming year.

Data sourced from the DHB patient management system.[5]

Measure: The percentage of the population presenting at ED.	12/13	13/14	Result 14/15	Target 14/15
	43%	42%	43%	<45%



[5] *This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10 but includes urgent care and emergency presentations for the full year and from all locations across the West Coast.*

IMPACT MEASURES MEDIUM TERM

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

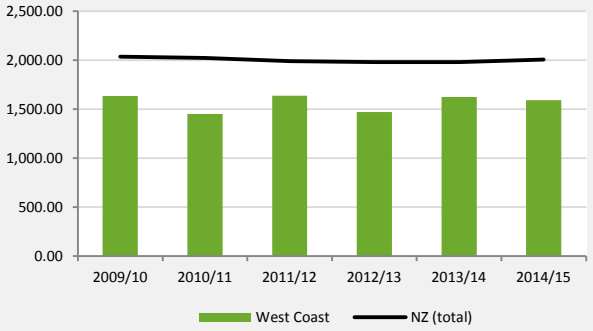
In the year to 31 March 2015, West Coast's avoidable hospital admission rate was 1,590 per 100,000 people. This is an improvement on the previous year, dropping to just 79% of the national rate (2,005 per 100,000).

A wide range of local initiatives contribute to preventing unnecessary admissions, including our primary care led Long-term Conditions Management Programme and our community-based Complex Clinical Care Network both of which support people to better manage their health and wellbeing.

Data sourced from the Ministry of Health. [6]

Measure: The ratio of actual to expected avoidable hospital admissions for our population (<75).

12/13	13/14	Result 14/15	Target 14/15
74%	82%	79%	≤95%



Impact: Children have improved oral health.

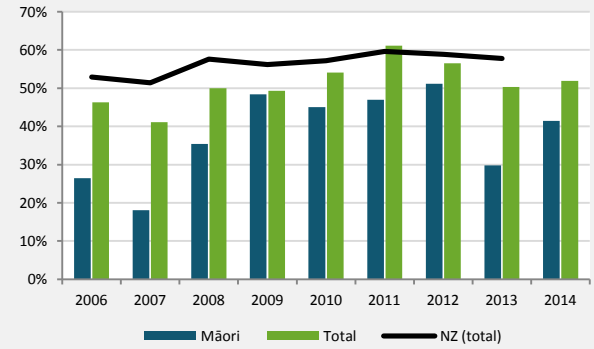
The percentage of five-year-olds caries-free has increased slightly from 50% to 52% and the results for Māori five-year-olds has jumped from 30% to 41%.

The small number of children involved means these results are subject to a greater degree of variation. However, improvements in the number of children enrolled in dental services and being examined on time are inputs that will have a positive effect on outcomes in future years.

Data sourced from Ministry of Health. [7]

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

	Result 2013	Result 2014	Target 2014
Māori	30%	41%	≥54%
Total	50%	52%	≥54%



[6] *This measure is a national DHB performance indicator (SI1) and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. Previously defined as the standardised rate per 100,000 in the population, it has been defined as a rate and the target is set to maintain performance below the national rate—which reflects less people presenting. There continues to be a definition issue with regards to the use of self-identified vs. prioritised ethnicity. While this has little impact on total population results it does have a material impact on Māori results against this measure, hence they have not been displayed. The Ministry is working to resolve this issue and reset the definitions for this measure. Target setting for 2015/16 has been postponed while the definitions are reset.*

[7] *The measure is a national DHB performance indicator (PP11) and national results were not available at the time of publishing.*

GOAL 3: People with complex illness have improved health outcomes

Why is this outcome a priority?

For people who do need a higher level of intervention, timely access to high quality complex care and treatment supports recovery, helps to slow the progression of illness and can reduce reliance on long-term or residential care. This not only leads to restored functionality and a better quality of life for those individuals but reduces unnecessary costs and improves public confidence in the health system. As the owner and provider of hospital services, this goal also reflects the quality of care and treatment provided by the DHB. Adverse events, long waits, or ineffective treatment can cause harm and result in longer hospital stays, unnecessary complications and readmissions—all of which have a negative impact on the health of our population and increase costs across the system.

OUTCOME MEASURES LONG TERM

Outcome: A reduction in avoidable mortality rates.

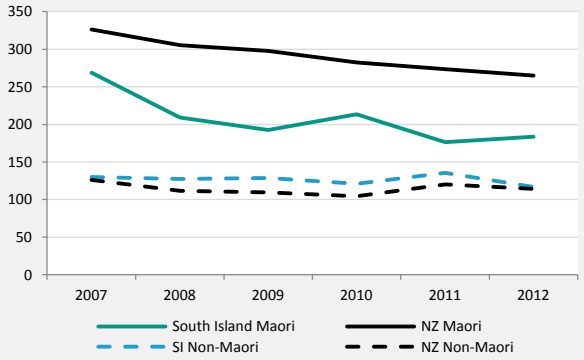
There has been a slight increase in the rate of all-cause mortality for South Island Māori between 2011 (176 per 100,000) and 2012 (184 per 100,000). However, the overall trend remains positive and consistently below national rates (the difference between years is 14 people).

A number of factors influence mortality rates and as such, positive trends are influenced by a range of programmes and initiatives in place across our health system.

Programmes to reduce smoking and obesity rates contribute to these lower rates. Our Long-term Conditions Management Programme, increased access to treatment and surgery and our restorative approach to home-based support also make a difference by improving people's health outcomes.

Data sourced from MoH mortality collection 2010 update.[8]

Measure: The rate of all-cause mortality for people aged under 65 (age-standardised per 100,000).



Outcome: A reduction in acute readmission rates.

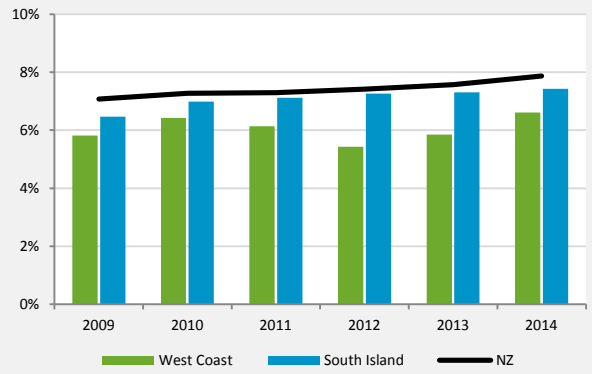
Small numbers have a disproportionate effect on the results between years for the West Coast. The difference in the actual number of readmissions between 2011 and 2014 is 7 people.

The trend being relatively stable and consistently below the national average is a positive result for the West Coast.

The DHB has continued to focus on improving access to restorative home-based support and has begun to implement the Enhanced Recovery After Surgery (ERAS) initiative designed to optimise surgical outcomes and support recovery after surgery.

Data sourced from Ministry of Health.[9]

Measure: The rate of acute readmissions to hospital within 28 days of discharge.



[8] *The data presented is the most current available sourced from the national mortality collection which is three years in arrears.*

[9] *This measure is a national performance indicator (OS8). The Ministry of Health is currently reviewing the definition for this measure and target setting has been delayed for 2015/16 while the definition is reset. The DHB has elected 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.*

IMPACT MEASURES MEDIUM TERM

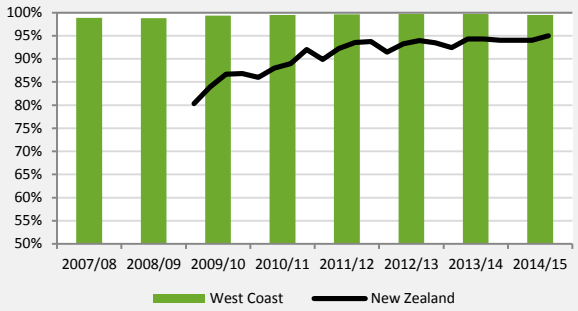
Impact: People have shorter waits for acute (urgent) care.

The West Coast has continued to maintain performance against the national Shorter Stays in ED health target, with over 99% of people presenting for urgent care being admitted or discharged within six hours.

Strong performance results are reflective of the success of inter-departmental and cross-sector teams in ensuring effective functioning and patient flow across the hospital which enables staff to respond within target timeframes.

Data sourced from individual DHBs.[10]

Measure: The percentage of people presenting at ED - admitted, discharged or transferred within six hours.	12/13	13/14	Result 14/15	Target 14/15
	99.7%	99.7%	99.5%	>95%



Impact: People have increased access to planned care.

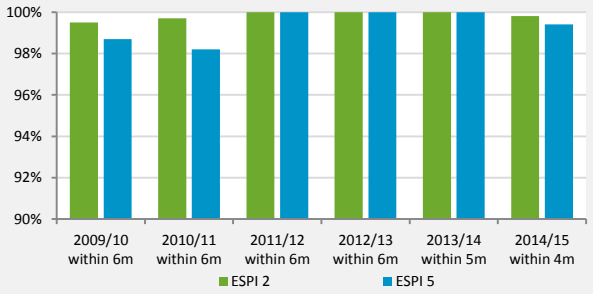
Waiting time targets have reduced from a maximum of five months to a maximum of four months for both First Specialist Assessment and Time to Treatment.

As at June 2015, 100% of people referred for a specialist assessment received their assessment within four months of referral, and 99.4% of those given a commitment for treatment began their treatment within four months.

Performance against these targets represents a major achievement for the West Coast DHB and is also reflective of the positive impact of the transalpine arrangements in place between the Coast and Canterbury DHBs.

Data sourced from Ministry of Health.[11]

Measure: Wait time from referral to First Specialist Assessment (ESPI 2).	12/13 <6mths	13/14 <5mths	Result 14/15	Target 14/15
	100%	100%	100%	<4
Measure: Wait time from commitment to treatment (ESPI 5).	100%	100%	99.4%	<4



Impact: People stay safe in our hospitals.

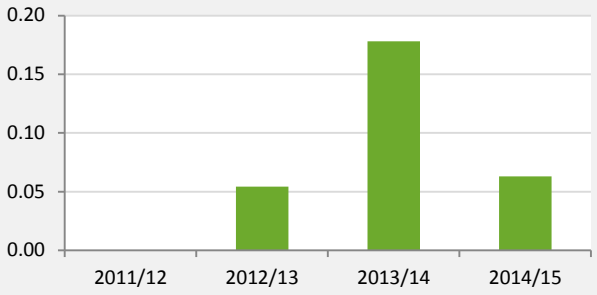
Small numbers present a disproportionate picture between years for this regional measure. The overall rate of serious falls remains low with 2 incidents in the past year.

Key projects have focused on standardising fall prevention visual cues, post-fall care and adoption of the national Falls Assessment process with 95% of all inpatients (aged 75+) receiving a falls assessment in the first quarter of this year (2015/16).

All serious incidents are individually reviewed by the quality and clinical teams in each department to identify cause and implement improvements.

Data sourced from individual DHBs.[12]

Measure: The rate of SAC level 1 and 2 falls in West Coast Hospitals.	12/13	13/14	Result 14/15	Target 14/15
	0.05	0.18	0.06	<0.05



[10] *This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10 but urgent care and ED presentations for the full year and from all locations across the West Coast.*

[11] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive individual performance reports from the Ministry of Health. The wait time target for 2014/15 was mixed - being a maximum of 5 months for Q1 and Q2 and a maximum of 4 months from January 2015. In line with the ESPI target reporting the annual results presented are those from the final quarter of the year (April-June).*

[12] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days and small numbers have a significant impact on these results. The 2013/14 result relates to 6 incidents and 2014/15 to 2 incidents.*

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

Why is this outcome a priority?

Even when returning to full health is not possible, access to responsive, needs-based services help people to maximise function with the least restriction and reduce both unnecessary hospital admissions and institutionalisation. There are also a number of services or intervention that focus on improving the quality of people's lives such as pain management or palliative services. This goal is not only about achieving a better quality of life for individuals but also about improving support for their families and freeing up health resources across the system.

OUTCOME MEASURES LONG TERM

Outcome: An increase in the proportion of the population living in their own home.

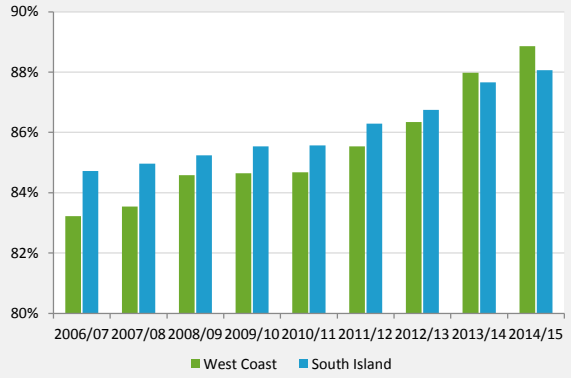
The percentage of the population living in aged residential care continues to drop and the proportion of the West Coast population (aged 75+) living in their own homes has reached 88%.

This positive result is consistent with our strategy of supporting people to stay safe and well in their own homes and communities.

Under the direction of our Complex Clinical Care Network a number of local programmes support older people on the West Coast to age in place including increased access to restorative home-based support services, district nursing services and respite services.

Data sourced from Client Claims Payments provided by SIAPO.[13]

Measure: The percentage of the population (75+) living in their own home.



IMPACT MEASURES MEDIUM TERM

Impact: People stay safe in their own homes.

At 7.2%, the percentage of the population (75+) admitted to hospital as a result of a fall is lower than the previous two years and remains lower than both the South Island and national results.

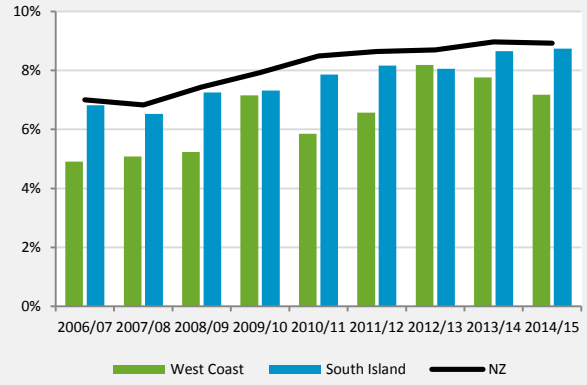
Falls are a significant risk for older people and compared to people who do not fall, those who do experience prolonged hospital stays, loss of confidence and independence and an increased risk of institutional care.

The solutions to reducing falls include addressing a variety of associated risk factors including medications use, reduced physical strength, poor nutrition, impaired vision and environmental hazards. A reduction in falls can therefore be seen as a proxy for improved health service provision for older people across a number of health services and clinical teams.

Further focus will be placed on reducing falls in the coming year with the establishment of a community based Falls Prevention and Fracture Liaison Service.

Data sourced from National Minimum Data Set.[13]

Measure: The percentage of the population (75+) admitted to hospital as a result of a fall.	12/13	13/14	Result 14/15	Target 14/15
	8.2%	7.8%	7.2%	7.8%



[13] *The population numbers here are based on the 2006 Census projections, which were the basis of the 2014/15 Annual Plan and Statement of Intent. These measures will be reset for the 2015/16 year based on the more recent 2013 Census projections. This is likely to result in a slight drop in rates as the West Coast 75+ population has been over-estimated, but the positive trends are expected to remain.*

STATEMENT OF SERVICE PERFORMANCE

Measuring our Non-financial Performance

As the major funder and provider of health services on the West Coast, we are strongly motivated to ensure we are delivering the most effective and efficient services possible. Understanding the dynamics of our population and the drivers of demand are fundamental when determining which services to fund and at what level. Just as fundamental is our ability to evaluate whether our investment is making a measureable difference in the health and wellbeing of our population.

As part of evaluating our performance, we provide an annual forecast of the services we plan to fund and provide and then report actual delivery against those expectations at the end of each year. The following presents the DHB's performance against the forecast presented in the Statement of Service Expectations from our 2014/15 Statement of Intent.

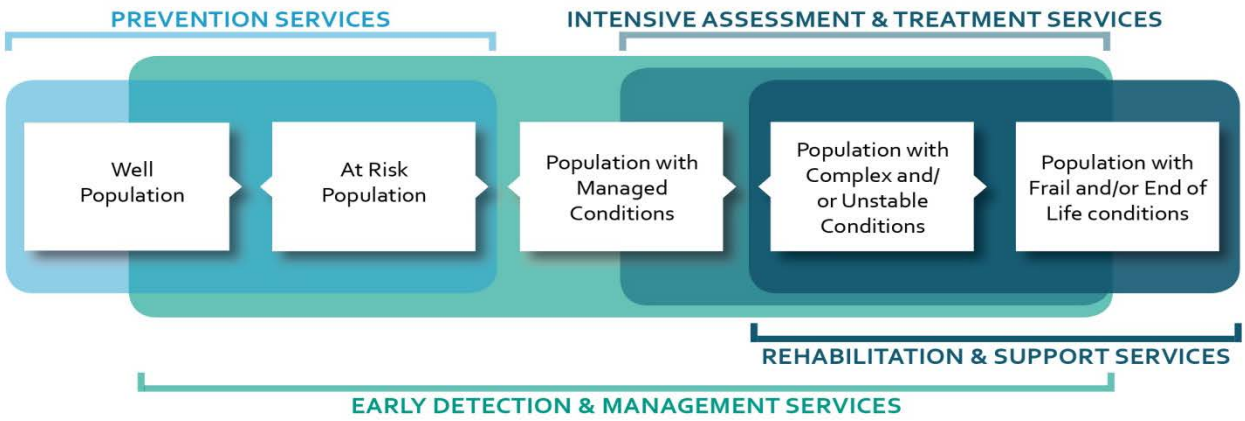
In presenting a picture of our performance, it would be overwhelming to measure every service or output delivered. We therefore choose to measure those activities with the greatest potential to contribute to the health and wellbeing of our population, those which are markers of broader system changes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

In doing so, we measure more than just volumes. Often the number of something 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, Quality, Timeliness and Coverage. Together, these measures demonstrate how we are contributing to the longer-term health outcomes we seek.

As well as comparing our 2014-15 results against the targets we set in our Statement of Intent, we have included (wherever possible) prior year's and national results to give wider context in terms of what we are trying to achieve and to enable the reader to assess performance over time.[14]

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 & Management Services, Intensive Assessment & Treatment Services, and Rehabilitation & Support Services. This helps to provide a picture of overall performance by grouping services with similar aims or goals.

Output Classes against the Continuum of Care for our Population



2014-2015 Performance Overview

Our performance result for 2014-15 shows good progress has been made across many areas. Results identify challenges not unexpected in a DHB of our size and, while we have not achieved every target, in a number of cases the delivery against target or the previous year's results has been missed or dropped by a very small number of people.

Performance against our health promotion targets has been particularly impressive and both smoking cessation and immunisation coverage results are positive. Delivery against the B4 School Checks target has remained high, helping to identify and resolve any health issues for children before they start school. Screening coverage rates in other areas are positive compared to national results but not as high as we would have liked and further focus is needed in this area.

The uptake of primary and community services has lifted considerably in a number of areas, with increased support for those people with long-term conditions and those needing additional mental health support (brief intervention counselling). Considerable effort has been placed on identifying and enrolling people with long-term conditions and enrolments in the PHO and primary care-led Long-term Conditions Programme has increased significantly over the past year. Oral health enrolments

[14] *Unless otherwise stated, the latest New Zealand results have been sourced from the Ministry of Health, national service units or national datasets.*

and the number of children examined on time have also both improved over the past year, reflecting the efforts of our school and community dental teams to reach these children.

The number of clinically-designed HealthPathways in place across our system also continues to grow, reflecting and supporting the increased integration between primary and secondary services.

Results demonstrate the system is delivering shorter waiting times in almost every area; oral health, diagnostic tests, cancer treatment and mental health services. Waiting times for diagnostic tests are shorter than national averages and we continue to provide 100% of patients with radiation and chemotherapy within four weeks of the decision to treat.

We delivered more virtual first specialist assessments (reducing travel and disruption for patients) and more elective surgery. Our average length of stay is below the national average and performance against the national quality markers has been positive in almost all but one area compared to previous years and national results.

Recruitment challenges have delayed the implementation of our supported discharge and falls prevention service but access to home and community support services, meals on wheels, and mental health respite have all increased—helping support people to remain in their own homes. In line with our strategic direction, rest home bed days have dropped over the past year.

In terms of delivery against the national health targets, the West Coast has achieved five of the seven targets. Performance has improved dramatically against both primary care health targets. The DHB achieved the primary care smoking target—improving 28% on last year's result—and also exceeded the cardiovascular risk assessment target—improving 14% on last year. We have continued to deliver on the elective surgery, hospital smoking, and ED wait time targets.

We missed the eight-month immunisation target by 5% (just nine children). The high number of opt-offs and declines on the West Coast will always make this a difficult target to achieve, however we have reached 98% of all eligible children in the past year which is a very positive result. A new faster cancer treatment target was introduced part way through the year (the percentage of patients to receive their first cancer treatment or management within 62 days of treatment) and the DHB has reached 50% against this new measure with a target of 85%.[15]. Further focus in the coming year should see us make more progress against this new target.

There are many positives in terms of our performance. Small numbers will always have a disproportionate effect on our results but trends and performance against the national result is reassuring and reflects the effort of many individuals and teams across our system.

Notes on the Data

This Annual Report incorporates a large number of measures related to services provided by the DHB or funded by the West Coast DHB but provided by third parties. This creates some additional considerations:

- Access to some health services is, by necessity, unrestricted or 'demand-driven' (such as emergency care, maternity services and palliative or dementia care). Due to the nature of these services we do not set targets. However, to give the reader an understanding of this demand and the use of resources across our health system, estimated volumes are included in our forecasts. Rather than footnote every instance, these are indicated by the abbreviation '**est.**'
- Some services are funded by the DHB but provided by third parties and performance results can be affected by a lag in invoicing or reporting. Rather than footnote every instance, a symbol is used to indicate where this is the case: **Δ.**
- Some service data is reported by calendar rather than financial years. In these cases, the '2013/14' result relates to the 2013 calendar year and the '2014/15' result to 2014. These are indicated with the following symbol: **†**.
- With regards to the national health targets, in line with national reporting and expectations final quarter results are presented (April-June). The following symbol indicates which measures are national health targets **◇.**
- Any other irregularities have been footnoted.

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child Health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental Health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs' 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

[15] *Detail on the Health Target performance can be found on the Ministry of Health website – www.moh.health.nz.*

OUTPUT CLASS
Prevention services

Why is this output class significant for the DHB?

Preventative health services help to promote and protect the health of the population by targeting changes to physical and social environments that engage, influence and support people to make healthier choices. In doing so, these services help to reduce behaviours and risk factors that contribute to the development of long-term conditions.

Because at-risk and high-need population groups are more likely to engage in risky behaviours and live in environments less conducive to making healthier choices, prevention services are our foremost opportunity to reduce inequalities in health status. Prevention services are also often designed to disseminate consistent messages to large numbers of people and can therefore be a cost-effective means of improving health outcomes.

Performance Summary

Increased focus has been placed on engaging our population in positive behaviours and it is pleasing to note that there continues to be high engagement in these areas and improved progress against almost all health promotion measures. Smoking prevention continues to be a major highlight, along with the high number of people enrolling in the Aukati Kaipaipa smoking cessation programme. The number of people accessing Green Prescriptions remains high and while not quite reaching target, more of those people taking up the green referral are remaining active. Considerable progress has been made against the national primary care smoking target, reflecting the dedication and effort made by our primary care teams and the West Coast PHO.

We have achieved the national target for delivery of B4 School Checks to ensure children get the best start to school. We are also pleased to have improved performance against the national targets for eight month old immunisations and reached 98% of all eligible children.

While our breast and cervical screening rates remain in line with national performance, both have dropped back against previous years and additional focus is needed to lift these rates back up. Performance is disappointing compared to our coverage target and engagement in other population health programmes. While small numbers have a significant impact on our HEEADSSS and Human Papilloma Virus (HPV) vaccination rates, results are still disappointing compared to coverage targets and we will still look to improve performance in these areas in the coming year.[16]

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with awareness, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of babies exclusively & fully breastfeeding on hospital discharge	Q [17]	92%	90%	84%	>75%	-	▼
Lactation support/specialist advice consults provided in community settings	V	149	117	172	>100	-	▲
Nutrition and Activity courses provided in the community	V	6	7	9	≥10	-	▲
People referred to Green Prescriptions for additional physical activity support	V [18]	374	474	478	500	-	▲
% of Green Prescription participants more active 6-8 months after referral	Q [19]	43%	80%	86%	50%	61%	▲
% of smokers identified in primary care receiving advice and help to quit (ABC)	C ◇	55%	62%	90%	90%	90%	▲
% of smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	95%	95%	98%	95%	96%	▲
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	124	129	175	>100	-	▲
% of priority schools supported by the Health Promoting Schools framework	C [20]	100%	100%	100%	>70%	-	–

[16] *A HEEADSSS assessment is provided to Year 9 students in decile 1-3 schools. It is free and covers: Home; Education/Employment; Eating; Activities; Drugs and alcohol; Sexuality; Suicide & depression; and Safety; and allows health concerns to be identified and addressed early.*

[17] *The percentage of babies' breastfeeding demonstrates the effectiveness of consistent health promotion messages delivered during the antenatal, birthing and early postnatal period. Standards are based on national targets. The drop in 2014/15 results may be related to improved data collection which provides more detail around the type of feeding and excludes mixed feeding rates, previous year's results specified only breast or bottle feeding.*

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

[19] *Results taken from national patient survey completed by Research NZ on behalf of the Ministry of Health.*

[20] *The Health Promoting Schools Framework addresses health issues through 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 *These services help to identify people at risk of illness and pick up long-term conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of four-year-olds receive a B4 School Check (B4SC)	C [21]	81%	90%	92%	90%	92%	▲
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C † [22]	55%	55%	46%	100%	-	▼
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [23]	78%	79%	75%	80%	76%	▼
% of women aged 50-69 having a breast cancer screen in the last 2 years	C [24]	81%	80%	75%	>70%	72%	▼

Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of newborns enrolled on the National Immunisation Register at birth	C	100%	100%	100%	95%	-	–
% of children fully immunised at eight months of age	C ◇	93%	81%	85%	95%	93%	▲
% of eight-month-olds 'reached' by immunisation services	Q ◇ [25]	97%	96%	98%	95%	97%	▲
% of Year 8 girls completing their HPV vaccinations (i.e. receiving Dose 3)	C † [26]	44%	54%	53%	60%	60%	▼
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	55%	63%	64%	75%	69%	▲

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

[22] *A HEADSS assessment is provided to Year 9 students in decile 1-3 schools. It is free and covers: Home; Education; Employment; Eating; Exercise; Activities; Drugs; Sexuality; Suicide; Safety; and Spirituality and allows health concerns to be identified and addressed early. Small numbers have a disproportional effect on the results between years and the difference between the actual number of checks delivered in 2013/14 and 2014/15 is 5 checks. The DHB is working with schools to review consent processes for the HEADSS assessments which is expected to increase the number of children participating.*

[23] *This is a national screening programme and standards are set to align with national screening targets. Cervical Screening results are to Q3 2014/15 being the most recent national results available.*

[24] *This is a national screening programme and standards are set to align with national screening targets. The age range for the national measure was changed mid 2014/15 from women aged 45-69 to women aged 50-69 and so the latest results are not directly comparable to previous years.*

[25] *'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children but have chosen to decline immunisations or opt off the NIR.*

[26] *Small numbers can have a disproportionate effect on these results with the difference between the 2013/14 and 2014/15 results being 3 girls who were yet to receive the third dose of the HPV vaccination – 55% of eligible girls had received dose 1 and 54% dose 2%.*

OUTPUT CLASS
Early detection and management services

Why is this output class significant for the DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age. By promoting regular engagement with health services we can support people to maintain good health and, through earlier diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes.

Because these services can better support people to stay well and stabilise or manage their condition, people are able to reduce complications, acute illness, and crises—and therefore avoid hospital appointments and admissions. Reducing this demand has a major impact in freeing up hospital and specialist services to allow for more planned interventions and reduced waiting times.

Performance Summary

It is positive to see that access to primary and community services remains high, suggesting that our population is engaging with their general practice. Access to diagnostics, long-term conditions management services and mental health support (brief intervention counselling) in the community, by reducing the need for hospital visits, reduces waiting times and enables earlier intervention.

Performance against the oral health measures has improved dramatically over the past year with the team targeting enrolment and timely examinations with the school and community dental service.

West Coast met the national target for delivery of cardiovascular risk assessments, and while diabetes reviews have dropped slightly compared to previous years, the focus has been on the development of the primary care-led Long-term Conditions Management Programme (LTCMP). Enrolment in this programme has increased considerably over the past year.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Primary Health Care (GP) Services *These services are offered in local community settings by general practice teams and are aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake of services are indicative of engagement and service accessibility.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of the total DHB population enrolled with a Primary Health Organisation	C	94%	92%	91%	95%	96%	▼
Avoidable hospital admission rate for children aged 0-4	Q [27]	102%	96%	85%	<101%	100%	▼
Young people (0-19) accessing Brief Intervention Counselling	V Δ [28]	62	65	126	80	-	▲
Adults (20+) accessing Brief Intervention Counselling	V Δ [21]	308	374	413	>300	-	▲
Number of HealthPathways in place across the West Coast health system	V [29]	308	434	614	>600	-	▲

Oral Health Services *These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of pre-school children (0-4) enrolled in DHB-funded oral health services	C †[30]	85%	75%	100%	90%	73%	▲
% of enrolled children (0-12) examined according to planned recall	T †	72%	78%	89%	90%	90%	▲
% of adolescents (13-17) accessing DHB-funded oral health services	C †	77%	72%	70%	85%	71.8%	▼

[27] *Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The measure is a national DHB performance indicator (SI1) and is defined as the standardised rate per 100,000 population. Baselines differ slightly to those previous published due to updated national data.*

[28] *The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. Baselines differ slightly to those previously published due improved data collection and the inclusion of late invoices. The increase in delivery in the past year has been enabled by an increase in staff resource.*

[29] *The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.*

[30] *The oral health measures are national DHB performance measures and are reported by calendar year - national results for 2014 year are yet to be released those presented relate to 2013.*

Long-term Conditions Management (LTCM) Programmes *These services are targeted at people with high health need due to having a long-term condition and aim to reduce deterioration, crises and complications through good management and control of that condition. Success is demonstrated through early intervention, monitoring and management strategies which reduce the negative impact and the need for hospital admission.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
People identified with a long-term condition enrolled in the LTCM programme	V [31]	2,552	2,767	3,666	>2,000	-	▲
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇ [32]	58%	77%	91%	90%	89%	▲
% of people with diagnosed diabetes having an annual LTCM review	C	70%	99%	96%	>70%	-	▼
% of people with satisfactory diabetes management	Q	78%	78%	69%	80%	-	▼

Pharmacy and Referred Services *These are services which a health professional may prescribe or refer a person to help diagnose a health condition, or as part of treatment. We target increased primary care access to diagnostics and shorter wait times to aid decision-making and improve referral processes.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Subsidised pharmaceutical items dispensed in the community	V Δ [33]	479k	445k	443k	est.<600K	-	▼
Laboratory tests completed for the West Coast population	V Δ [34]	N/A	N/A	N/A	est.<150K	-	–
Number of community requested radiological tests delivered by Grey Hospital	V	5,721	5,590	5,935	est.>5k	-	▲
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T ◇ [35]	53%	33%	92%	75%	75%	▲
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T ◇	100%	100%	100%	≥90%	85%	–
% of people receiving their Magnetic Resonance Imagining (MRI) within 6 weeks	T ◇ [36]	91%	92%	88%	≥80%	54%	▼

[31] *The significant increase in LCTM Programme enrolments in 2014/15 is attributed to an increased LTCM activity focus in practices including update to the 'Patient Dashboard' that now includes LTCM alerts.*

[32] *This measure refers to CVD Risk Assessments undertaken in primary care in line with the national 'More heart and diabetes checks' health target, with the significant increase in coverage due to an increased focus on achievement of the national target including the installation of Patient Dashboards—which prompts health professionals when patients are due for their assessment.*

[33] *This measure covers all items dispensed in the community rather than hospital; however, it may still include some non-West Coast residents who had prescriptions filled while on the Coast.*

[34] *This measure was in anticipation of this information being available however while processes for collecting this information now been finalised, data backlogs have unfortunately meant that result were still not available at the time of printing.*

[35] *All diagnostic results are as at 30 June in line with results published by the Ministry of Health - targets are set to match national standards set for all DHBs. Small numbers have a disproportionate effect on these results — the actual number of diagnostic colonoscopies delivered for example was only 8 more in 2014/15 than in 2013/14*

[36] *Small numbers have a disproportionate effect on this result — the actual number of MRIs delivered was only 3 less in 2014/15 than in 2013/14.*

OUTPUT CLASS

Intensive assessment and treatment services

Why is this output class significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve health outcomes, either through early intervention or through corrective action. People are then able to establish more stable lives, resulting in improved quality of life and increased public confidence in the health system. As an owner of these services, the DHB is committed to providing high quality services which will not only ensure patient safety but reduce adverse events and delays in treatment—all of which, as well as causing harm to patients, drive unnecessary costs and redirect resources away from services.

Performance Summary

Performance has been positive across this output class and while a number of areas are demand driven, access has improved in a number of service areas and quality and coverage measures indicate improved engagement with staff and with patients.

An increasing proportion of our specialist assessments and outpatient appointments are being delivered virtually and via telemedicine technology. This often means that patients are able to be seen by a specialist without having to travel, which is less disruptive for them and their families and a better use of health resources. Although the number of First Specialist Assessments delivered remains above target, the total volumes have fallen slightly reflecting improvements in the model of care. The increasing use of HealthPathways has meant those being referred for First Specialist Assessments are more likely to require specialist input with a higher conversion rate to elective surgery. This is evidenced by the increased number of elective surgeries – more than ever before - with less time spent waiting. It is early to draw too many conclusions but the increased support provided by general practice, the complex clinical care network and AT&R services may also be having an influence on assessments and outpatient attendances with people receiving care and support closer to their own homes rather than in our hospital services.

Shorter waiting times have also been maintained across urgent care and cancer services. The average length of stay in our hospitals is still short and remains below national averages. Our Assessment, Treatment and Rehabilitation (AT&R) teams have improved access and increased the proportion of people engaged with AT&R services being supported to return to their own homes.

Progress against the national quality markers continues to be largely positive with the DHB having reached targets and improved or maintained performance against all but one of the national indicators.

While the adult access rate for specialist mental health services has dropped against last year, this is still above target and high input from primary care services in terms of brief intervention counselling may be having a positive impact in this area—with fewer people needing specialist support. Reducing wait times for mental health services is still an area of focus in the coming year. Did not attend rates also need further work in the coming year.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in West Coast hospitals and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Rate of compliance with good hand hygiene practice	Q ◇[37]	73%	77%	83%	80%	77%	▲
% of hip and knee replacement patients receiving cefazolin ≥2g	Q ◇[38]	New	89%	100%	95%	90%	▲
% of hip and knee replacement patients who have appropriate skin preparation	Q ◇[39]	New	100%	100%	100%	98%	–
% of time all three parts of the surgical safety checklist are used	Q ◇[40]	84%	96%	94%	90%	93%	▼
% of inpatients (aged 75+) who received a falls assessment	Q ◇[41]	53%	89%	95%	90%	90%	▲

[37] *This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. Baseline results differ due to alignment with national results and financial years. The 2014/15 result relates to the June 2015 audit period.*

[38] *Cefazolin ≥2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications. Results are the most recent quarter available nationally to December 2014.*

[39] *Results are the most recent quarter available nationally to December 2014.*

[40] *The surgical safety checklist, developed by the World Health Organisation, is a common sense approach to ensuring the correct surgical procedures are carried out on the correct patient. Previously published results differ due to alignment with national results and financial years. The 2014/15 results is the most recent quarter available nationally at the time of publishing to March 2015.*

[41] *While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and acting accordingly. The 2014/15 results is the most recent quarter available nationally at the time of publishing to March 2015.*

Maternity Services *These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided by a range of health professionals, including lead maternity carers, general practice teams and obstetricians.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of women registered with an LMC by 12 weeks of pregnancy	C †[42]	62%	62%	56%	80%	66%	▼
% of new mothers attending DHB-funded parenting and pregnancy courses	C [43]	New	N/A	69%	>30%	-	▲
Maternity deliveries in West Coast DHB facilities	V	325	279	256	est.300	-	▼
Baby friendly hospital accreditation of DHB facilities	Q [44]	Yes	Yes	Yes	Yes	-	–

Acute/Urgent Services *These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly (they may or may not lead to hospital admission). Utilisation and wait times are monitored to demonstrate responsiveness to need.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of children under six with access to free primary care outside business hours	C	100%	100%	100%	100%	-	–
% of general practices providing telephone triage outside business hours	C [45]	100%	100%	88%	100%	-	▼
Attendances at West Coast Emergency Departments (EDs)	V [46]	14,359	14,051	14,297	≤15,000	-	▲
% of people presenting in ED (Triage 1-3) seen within clinical guidelines	Q [47]	87%	87%	85%	>85%	-	▼
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T ◇ [48]	100%	100%	100%	100%	100%	–
Acute inpatient average length of hospital stay (standardised)	Q [49]	3.27	3.06	3.17	≤3.27	3.89	▲

[42] *Results differ from those previously published after alignment with national reporting to calendar years and as a result of the inclusion of DHB LMC data into the national database. The 2014/15 result is expected to improve once internal data from the DHBs system is verified and uploaded in the national database. Result reflects women registered by 12 weeks from those women registered across all trimesters.*

[43] *This data includes homebirths at the Gloriavale community, where mothers do not engage with the DHB funded Pregnancy and Parenting Education.*

[44] *The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises achievement of the standard.*

[45] *The drop to 88% represents one new practice who currently redirects callers to Healthline after hours.*

[46] *This measure is based on the national ED health target – but includes urgent medical and emergency presentations for the full year and from all locations across the West Coast (Greymouth, Buller and Reefton).*

[47] *Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.*

[48] *This measure is a national performance measure (PP30) and refers to all people 'ready for treatment' excluding Category D patients, whose treatment is scheduled with other treatments or as part of a trial. The national result is the most recently available which was to the end of Q1 (September) 2014/15.*

[49] *This measure is a national performance measure (OS3). When seeking to reduce average length of hospital stay, performance should be balanced against readmissions rates to ensure earlier discharge is appropriate and service quality remains high.*

Elective/Arranged Services *These are 'booked' or 'arranged' services for people who do not need immediate hospital treatment. Utilisation is monitored to ensure service levels are maintained and the DHB is responsiveness to need.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
First Specialist Assessments provided (medical and surgical)	V [50]	6,724	6,864	6,663	est.>6.5k	-	▼
% of First Specialist Assessments that were non-contact	Q [51]	5.0%	4.2%	5.5%	>5%	-	▲
Elective surgical discharges delivered (surgeries provided)	V [52]	1,686	1,695	1,721	1,592	-	▲
Elective inpatient average length of hospital stay (standardised)	Q [49]	3.30	3.14	2.87	≤3.18	3.19	▼
Specialist outpatient attendances	V [53]	15,478	15,565	13,972	est.>14.5k	-	▼
% of outpatient appointments/consultations provided by telemedicine	Q	1.5%	2.1%	2.1%	>1.5%	-	–
Outpatient 'Did not Attend' rates (total population)	Q [54]	8.3%	8.5%	7.8%	<6%	-	▼
Outpatient 'Did not Attend' rates (Māori)	Q	15.8%	18.0%	16.2%	<6%	-	▼

Specialist Mental Health Services *These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of young people (0-19) accessing specialist mental health services	C Δ [55]	6.1%	6.1%	6.1%	>3.8%	3.5%	–
% of adults (20-64) accessing to specialist mental health services	C Δ	4.9%	5.4%	5.0%	>3.8%	3.8%	▼
% of people referred for non-urgent MH/AOD services seen within 3 weeks	T [56]	72%	76%	77%	80%	79%	▲
% of people referred for non-urgent MH/AOD services seen within 8 weeks	T	91%	93%	93%	95%	93%	–

Assessment, Treatment and Rehabilitation Services (AT&R) *These are services provided to restore functional ability and enable people to live as independently as possible. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Admissions into inpatient AT&R services	V	125	131	124	est.>150	-	▼
Consultations provided by outpatient and domiciliary AT&R services	V	1,601	2,060	3,194	est.>1.7k	-	▲
% of AT&R inpatients discharged to their own home rather than into ARC	Q Δ [57]	90%	89%	83%	≥90%	-	▼

[50] *This measure is aligned to the national elective services reporting definitions which are run by DHB of domicile - covering all FSAs provided for West Coast residents no matter where they are delivered. The measure counts both medical and surgical assessments but only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred.*

[51] *Non-contact FSAs are those where specialist advice and assessment are provided without the need for a hospital appointment.*

[52] *This measure is a national performance measure (the electives health target) and the definition excludes 'arranged' cardiology and dental volumes.*

[53] *The results against this measure differ to those previously reported due to improved coding and clarity around the definition this measure covers DHB funded specialist attendances (medical, surgical and obstetric) on the West Coast only.*

[54] *The DNA results differ slightly to those previously published due to clarification and alignment of data definitions and timeframes and the inclusion of late coding for previous years.*

[55] *This measure is a national performance measures (PP6) and targets are based on the assumption that 3% of the population will need access to specialist mental health services. Results reflect only those specialist services (DHB and NGO) reporting through to the national PRIMHD database and may undercount service provision if providers are not reporting to the national system.*

[56] *The wait time measures are national performance measures (PP8) and results are provided three months in arrears to March 2015.*

[57] *While living in ARC is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. Discharge from AT&R to home (rather than ARC) reflects the quality of services in terms of assisting that person to regain their functional independence. The measure excludes those who were ARC residents prior to AT&R admission. Small numbers have a disproportionate effect on the results for this measure. The drop in performance between 2013/14 and 2014/15 reflects a difference of just 6 people.*

OUTPUT CLASS
Rehabilitation and support services

Why is this output class significant for the DHB?

Services that support people to live safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. Even when returning to full health is not possible, timely access to support enables people to maximise their function and independence. In preventing deterioration and crisis, these services have a major impact on the sustainability of the health system by reducing acute demand, avoidable hospital admissions and the need for more complex intervention. These services also support the flow of patients by enabling them to go home earlier and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

Performance Summary

In line with our strategic direction access rates for long-term and home and community based support including meals on wheels and mental health respite services are increasing and rest homes bed numbers continue to drop.

Further work is needed around consistent use of InterRAI assessment tools and recruitment challenges have delayed the introduction of the rapid response/support discharge (FIRST) and community falls prevention service. These will be a priority for the 2015/16 year.

Utilisation of the Liverpool Care Pathway has dropped following the release of a negative evaluation of the programme overseas. While the delivery of the programme is slightly different in this country uptake has not surprisingly been effected. New national End of Life Guidelines are being developed for implementation in the coming year.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. Success is measured through increased referral of the right people to these services.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C [58]	39%	55%	41%	80%	-	▼
People supported by the rapid response/supported discharge service (FIRST)	V [59]	New	New	N/A	50	-	–
People (65+) access community-based falls prevention services	V [60]	New	New	N/A	yes	-	–

Home-Based Support Services *These are services designed to support people to continue living in their own homes by restoring functional independence. Success is measured against decreased or delayed entry into residential or hospital services.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	Q Δ [61]	83%	94%	93%	>95%	-	▼
People supported by long-term home and community support services	V Δ	734	751	792	est.>740	-	▲
Community-based district nursing visits provided (long-term clients only)	V Δ	4,913	4,364	4,171	est.>5k	-	▼
Meals on Wheels provided	V	35,234	33,082	37,306	est.>37k	-	▲

[58] *Small patient numbers have a disproportionate effect on results for this measure year-on-year—however, the DHB is still working with the wider South Island Stroke Network to improve these results and the journey for patients with stroke and to implement the NZ Stroke Guidelines on the West Coast.*

[59] *This measure was set with anticipation that this service would be in place and operational by Q4 of the 2014/15 year. Unfortunately the DHB has had trouble recruiting for the new roles and the start of the service has been delayed. It is expected to get up and running early 2015/16*

[60] *This measure was set with anticipation that this service would be in place and operational by Q4 of the 2014/15 year. Unfortunately the DHB has had trouble recruiting for the new roles and the start of the service has been delayed. It is expected to get up and running early 2015/16*

[61] *InterRAI is an evidence-based geriatric assessment tool, the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care.*

Respite and Day Services *These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are expected to increase over time, as more people are supported to remain in their own homes.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Mental health planned and crisis respite service bed days used	C Δ	483	379	457	est.>500	-	▲
Occupancy rate of mental health planned and crisis respite beds	C Δ[62]	71%	51%	63%	85%	-	▲
People supported by aged care respite services	V	58	64	56	est.70	-	▼

Palliative Care Services *These are services that improve the quality of life of patients facing terminal illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
ARC facilities trained to provide the Liverpool Care Pathway option to residents	V	3	5	5	4	-	–
People in ARC services supported by the Liverpool Care Pathway	V [63]	31	12	N/A	>30	-	▼

Residential Care Services *These services are provided to meet the needs of people assessed as requiring long-term residential care in a hospital or rest home. With an ageing population, a decrease in the number of subsidised bed days for lower-level care is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of people entering ARC having had a clinical assessment of need using InterRAI	Q Δ[61]	99%	97%	97%	95%	-	–
% of ARC residents receiving vitamin D supplements	C [64]	57%	59%	59%	75%	-	–
Subsidised ARC rest home beds provided (days)	V Δ[65]	43,573	44,438	42,324	est.<50k	-	▼
Subsidised ARC hospital beds provided (days)	V Δ[65]	40,821	41,352	40,759	est.<40k	-	▼
Subsidised ARC dementia beds provided (days)	V Δ[65]	2,805	4,551	6,607	est.>3k	-	▲
Subsidised ARC psycho-geriatric beds provided (days)	V Δ[65]	3,729	2,394	2,747	est.>4k	-	▲

[62] *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 underutilised and could be better directed to other areas.*

[63] *The Liverpool Care Pathway is an international palliative care programme adopted nationally. The drop off in use of the Liverpool Care Pathway reflects the reputational damage resulting from a negative review of the programme overseas. The DHB has been focusing on supporting the development of national End of Life Guidelines which will include appropriate training and a local referral pathway.*

[64] *ARC Vitamin D supplementation results are provided by ACC. The result provided is for the three months to June 2015.*

[65] *All baseline ARC bed day results for 2013/14 differ to that previously published due to the inclusion of late invoices. The large increase in the number of dementia bed days provided in 2015/16 is due to a change in practice and the recognition of dedicated dementia beds rather than top-up payments for dementia care.*

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 Māori Health Action Plan require a continued and collaborative effort from across the whole of our health system.

The disproportionate effect of small population numbers is particularly evident with the measures Māori Health Action Plan where the results can jump around between years, for example, we were only three children off meeting our 8-month-old immunisation target this year. Overall performance is relatively stable across the mix of measures and positive results across breastfeeding, smoking and cardiovascular risk assessment indicators. Like our total population results, Māori cervical and breast screening trends are less positive and are areas where additional focus will be needed to improve results.

Māori Health Action Plan Indicators		Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of the population enrolled with a PHO		C	93%	92%	90%	≥95%	-	▼
Avoidable hospital admission rate for children aged 0-4 years		Q	197%	183%	117%	<101%	100%	▼
Avoidable hospital admission rate for adults aged 45-64 years		Q	147%	162%	112%	<95%	100%	▼
Avoidable hospital admission rate for adults aged 0-74 years		Q	166%	136%	117%	<95%	100%	▼
% of tamariki fully and exclusively breastfed	Age 6 weeks	Q	69%	52%	53%	≥74%	66%	▲
% of tamariki fully, exclusively and partially breastfed	Age 6 months	Q	57%	58%	50%	≥59%	66%	▲
% of the eligible population having a CVD Risk Assessment in the last 5 years		C ◇	59%	77%	88%	90%	85%	▲
% of high-risk patient receiving an angiogram within 3 days of admission		T [66]	New	N/A	N/A	70%	N/A	–
% of patients presenting with ACS who undergo angiography have completion of register data collection within 30 days		T	New	N/A	N/A	95%	N/A	–
% of women aged 25-69 having a cervical cancer screen in the last 3 years		C [67]	69%	73%	62%	80%	63%	▼
% of women aged 50-69 having a breast cancer screen in the last 2 years		C [68]	79%	78%	76%	≥75%	64%	▼
% of smokers identified in primary care receiving advice and help to quit		C ◇	55%	62%	90%	90%	-	▲
% of smokers identified in hospital receive advice and help to quit		C ◇	98%	84%	100%	95%	-	▲
% of Māori smoking cessation enrolments		Q	12%	16%	16%	>12%	-	–
% of tamariki fully immunised at eight months of age		C ◇	100%	94%	80%	95%	90%	▼
% of the eligible population (65+) who have had an influenza vaccination		C † [69]	66%	72%	69%	75%	-	▼
% of Tamariki (0-4) enrolled in school and community dental services		C † [70]	66%	66%	88%	90%	59%	▲
Rate of Rheumatic Fever in the South Island (per 100,000)		Q	0.7	0.4	0.4	0.3	3.0	–
Rate of Compulsory Treatment Orders (per 100,000)		V	147	87	54	N/A	277	▼
% of 'Did-Not-Attend' (DNA) outpatient appointment for Maori		Q	15.8%	18.0%	16.2%	<14%	-	▼

[66] At the time of publishing this data was not available by ethnicity. For the month of June 2015, 7 of 7 people (100%) received an angiogram within 3 days of admission and the registry was completed for 7 of 7 people (100%) within 30 days of undergoing angiography.

[67] The cervical screening results are to Q2 2014/15 (Oct-Dec) being the most recent results available.

[68] The national breast screening eligibility criteria was changed mid 2014/15 to women 50-69 years rather than 45-69. The baseline results differ due to an update of the age bands and full year's result being used that we not available at the time for printing in 2013/14.

[69] These results differ from those previously reported which were 'high need' population results - this now reflects Maori only results and is taken from the Q2 result (Oct-Dec) being the end of the calendar year from PHO Performance Reporting.

[70] These result are provided annually for the calendar year - the NZ results are 2013/14 being the most recent available at the time of printing.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders on the affairs of the Board for the year ended 30 June 2015.

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, West Coast DHB recorded a net deficit of $1.047M against the budgeted deficit of $1.0M (2013/14 result was a net deficit of $1.087M).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	Board		QFARC		HAC		CPH&DSAC	
	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended
Peter Ballantyne	8	8	8	8	8	8	8	8
Kevin Brown	8	8			8	8		
Helen Gillespie	8	8	8	7				
Michelle Lomax	8	6					8	4
Peter Neame	8	8			8	8		
Sharon Pugh	8	8			8	8		
Elinor Stratford	8	7	8	8			8	8
Joseph Thomas	8	6	7	5			1	1
John Vaile	8	6					8	7
Susan Wallace	8	6	8	5				
Warren Gilbertson[1]			7	6				
John Ayling [2]							4	2
Lynnette Beirne							8	6
Dr Cheryl Brunton							8	7
Jenny McGill							8	4
Mary Molloy[3]							7	6
Robyn Moore[4]							5	4
Joe Mason[5]							6	5
Paula Cutbush					8	7		
Gail Howard					8	6		
Richard Wallace					8	5		
Chris Lim[6]					7	7		

QFARC = Quality, Finance, Audit and Risk Committee HAC = Hospital Advisory Committee

CPH&DSAC = Community and Public Health & Disability Support Advisory Committee

1 Appointed August 2014
2 Resigned December 2014
3 Appointed August 2014
4 Resigned February 2014
5 Appointed September 2014
6 Appointed August 2014

BOARD FEES

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

	Year ended 30 June 2015		
	Board	Advisory Committee	Total
Board members			
Peter Ballantyne	33,600	2,000	35,600
Kevin Brown	16,320	2,000	18,320
Helen Gillespie	16,320	2,188	18,508
Michelle Lomax	16,320	1,000	17,320
Peter Neame	16,320	2,000	18,320
Sharon Pugh	16,320	2,500	18,820
Elinor Stratford	16,320	4,500	20,820
Joseph Thomas	16,320	1,500	17,820
Susan Wallace	16,320	1,250	17,570
John Vaile	16,320	1,750	18,070
Advisory committee members			
John Ayling (CPH&DSAC)	-	500	500
Lynette Beirne (CPH&DSAC)	-	1,500	1,500
Dr Cheryl Brunton (CPH&DSAC)	-	-	-
Paula Cutbush (HAC)	-	1,750	1,750
Warren Gilbertson (QFARC)	-	1,500	1,500
Gail Howard (HAC)	-	1,500	1,500
Chris Lim (HAC)	-	1,750	1,750
Jenny McGill (CPH&DSAC)	-	1,000	1,000
Joe Mason (CPH&DSAC)	-	1,250	1,250
Mary Molloy (CPH&DSAC)	-	1,500	1,500
Robyn Moore (CPH&DSAC)	-	1,000	1,000
Richard Wallace (HAC)	-	1,250	1,250
	180,480	**32,688**	**213,168**

The West Coast DHB carries Directors and Officers Liability insurance and letters of indemnity have been arranged which cover the actions of Board members and employees of West Coast DHB.

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2015

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

Peter Ballantyne *Chair*	• 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 DHB • Director, Brackenridge Estate Limited
Kevin Brown *Board Member*	• Councillor, Grey District Council • Trustee, West Coast Electric Power Trust • Wife works part time at Child and Adolescent Mental Health Services • Patron and Member, West Coast Diabetes • Trustee, West Coast Juvenile Diabetes Association
Helen Gillespie *Board Member*	• Peer Support Counsellor, Mum 4 Mum • Employee, Department of Conservation
Michelle Lomax *Board Member*	• Autism New Zealand – Member • West Coast Community Trust – Trustee • Buller High School Board of Trustees – Chair • St John Youth Leader • New Zealand School Trustees Association – Member of Marlborough/ Nelson/West Coast Regional Executive
Peter Neame *Board Member*	• White Wreath Action Against Suicide – Member
Sharon Pugh *Board Member*	• Shareholder, New River Bluegums Bed & Breakfast • Chair, Greymouth Business & Promotions Association
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 • Chair of Victim Support, Grey/Westland District • Committee Member, Abbeyfield Greymouth Incorporated • Trustee, Canterbury Neonatal Trust • Elected Member, Arthritis New Zealand, Southern Regional Liaison Group

Joseph Thomas *Board Member*	• Chief Executive, Development West Coast • Ngati Mutunga o Wharekauri Asset Holding Company Limited – Chair • Motuhara Fisheries 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
John Vaile *Board Member*	• Director, Vaile Hardware Ltd • Member of Community Patrols New Zealand
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 DHB • Father is a member of the Hospital Advisory Committee • Member of Tatau Pounamu • Father is an employee of West Coast DHB • Director, Kōhatu Makaawhio Ltd • Appointed board member of Canterbury DHB • Chair, Poutini Waiora • Area Representative-Te Waipounamu Maori Women's Welfare League
John Ayling *CPH&DSAC Committee*	• Chair of Access Home Health, a subsidiary of Rural Women New Zealand which has a contract with West Coast DHB • 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 • Consumer Representative on West Coast DHB Falls Coalition Committee • Consumer Representative on West Coast DHB Stroke Coalition Committee

Dr Cheryl Brunton *CPH&DSAC Committee*	• Medical Officer of Health for West Coast - employed by Community and Public Health, Canterbury DHB • 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 – Drug Injecting Services in Canterbury Trust
Paula Cutbush *HAC Committee*	• Owner and stakeholder of Alfresco Eatery and Accommodation • Daughter involved in Green Prescriptions
Warren Gilbertson *QFARC Committee*	• Chief Operating Officer, Development West Coast • Director, Development West Coast Subsidiary Companies • Trustee, West Coast Community Trust
Gail Howard *HAC Committee*	• Trustee, Buller Electric Power Trust • Director, Energy Trust New Zealand
Chris Lim *HAC Committee*	• No interests to declare
Jenny McGill *CPH&DSAC Committee*	• Husband employed by West Coast DHB • Member, Parents Centre • Peer Support – Mum4Mum
Joe Mason *CPH&DSAC Committee*	• Representative of Te Runanga o Kati Wae Wae Arahura • Employee Community and Public Health, Canterbury DHB
Mary Molloy *CPH&DSAC Committee*	• Spokesperson for Farmers Against 1080 • Director, Molloy Farms South Westland Ltd • Trustee, L.B. & M.E. Molloy Family Trust • Executive Member, Wildlands Biodiversity Management Group Inc. • Chair of the West Coast Community Trust
Robyn Moore *CPH&DSAC Committee*	• Member of the West Coast Clinical Board • Consumer Representative on South Island Quality & Safety SLA • Sister (Julie Lucas) Acting Nurse Manager, Clinical Services

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 DHB • 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 New Zealand Nursing Organisation • Te Runanga o Aotearoa New Zealand Nursing Organisation • Member of the National Asthma Foundation Maori Reference Group • Kaumatua/Cultural Advisor for Child Youth & Family (Greymouth and Nelson)

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board a 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 INFORMATION

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

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made payments to former employees in respect of the termination of their employment. 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 2015, 3 (2014: 6) employees received payments relating to the termination of their employment totalling $299,660 (2014: $265,772), excluding retiring gratuities paid out. No Board members received compensation or other benefits in relation to cessation (2014: $nil).

REMUNERATION OF EMPLOYEES

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

	2015 Actual	2014 Actual
100,000 - 109,999	21	19
110,000 - 119,999	12	12
120,000 - 129,999	6	3
130,000 - 139,999	6	4
140,000 - 149,999	4	7
150,000 - 159,999	5	3
160,000 - 169,999	1	1
170,000 - 179,999	2	1
180,000 - 189,999	-	1
190,000 - 199,999	-	-
200,000 - 209,999	1	1
210,000 - 219,999	1	1
220,000 - 229,999	1	2
230,000 - 239,999	1	4
240,000 - 249,999	1	2
250,000 - 259,999	4	2
260,000 - 269,999	3	1
270,000 - 279,999	1	-
280,000 - 289,999	2	2
290,000 - 299,999	2	4
300,000 - 309,999	2	2
310,000 - 319,999	2	1
320,000 - 329,999	2	2
330,000 - 339,999	-	-
340,000 - 349,999	-	1
350,000 - 359,999	-	1
360,000 - 369,000	2	1
370,000 - 379,999	1	-
Total employees	84	78

84 employees (2014: 78) 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 DHB as an outsourced service.

Of the 84 employees shown, 75 are clinical employees (2014: 74) and are 9 non clinical employees (2014: 4).

STATUTORY INFORMATION

This Annual Report outlines the West Coast DHB's financial and non-financial performance for the year ended 30 June 2015. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

- Promote messages related to improving lifestyle choices, physical activity and nutrition and reducing risk behaviours such as smoking, to improve and protect the health of individuals and communities
- Work collaboratively with the primary and community health sectors to provide an integrated and patient-centred approach to service delivery.
- Develop continuums of care and patient pathways that help to better manage long-term conditions and reduce acute demand on hospital services
- Work with our hospital and specialist services to provide timely and appropriate quality services to our population and improve productivity, efficiency and effectiveness
- Take a restorative approach through better access to home and community-based support, rehabilitation services and respite care to support people in need of personal health or disability services to better manage their conditions, improve their wellbeing and quality of life and increase their independence
- Collaborate across the whole health system to reduce disparities and improve health outcomes for Māori and other high-need populations and to increase their participation in the health and disability sector
- Actively engage health professionals, providers and consumers of health services in the design of health pathways and service models that benefit the population and support a partnership model that provides a strong and viable voice for the community and consumers in health service planning and delivery
- Uphold the ethical and quality standard expected of public sector organisations and of providers of health services.
- Have processes in place to maintain and improve quality, including certification and a range of initiatives and performance targets aligned to national health priority areas and the Health Quality and Safety Commission 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	47.4
Nursing	50.9
Allied Health	51.2
Support	57.2
Management & Administration	49.5

Staff Mix by Gender	Number	Percentage
Female	957	85%
Male	172	15%
Total	1,129	

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	4
Australian	9
British	29
Chinese	4
Filipino	5
Indian	23
Maori	32
Middle Eastern	3
New Zealand European	358
New Zealander	2
Not Stated / Don't Know	637
Other	3
Other African	2
Other Asian	4
Other European	6
Pacific Peoples	4
South African	4

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, Safety and Wellbeing 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 which includes health and safety committees and 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 Workplace Safety Management Practices Programme to promote a safe work environment. Injury prevention programmes are developed to reduce the risk of injury and there is a focus on supporting staff to return to work following an injury or illness. We do not tolerate any form of harassment or workplace bullying and ensure all staff are 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.

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 South Island and lower North Island 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 in 2015/16. This process also identifies and provides input to the development needs of individuals.

STATEMENT OF RESPONSIBILITY

We are responsible for the preparation of West Coast DHB financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by West Coast DHB under section 19A of the Public Finance Act 1989. We have not included the end of year performance information on all appropriations as required by this section. As stated in the Statement of Service Performance, the Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of West Coast DHB for the year ended 30 June 2015.

Signed on behalf of the Board:

Peter Ballantyne
Chair
30 October 2015

Helen Gillespie
Chair, Quality, Finance, Audit & Risk Committee
30 October 2015

STATEMENT OF COMPREHENSIVE REVENUE & EXPENSES

For the year ended 30 June 2015

in thousands of New Zealand dollars

	Note	2015 Actual	2015 Revised Budget	2015 Original Budget	2014 Actual
Revenue					
Paitent care revenue	2	138,699	137,854	138,854	135,794
Other operating revenue	3	645	735	735	629
Interest revenue	6a	517	588	588	608
Total revenue		139,861	139,177	140,177	137,031
Expenses					
Employee benefit costs	5	57,840	55,613	55,613	55,477
Depreciation and amortisation expense	8,9	4,238	3,937	3,937	4,475
Outsourced services	4a	7,255	6,068	6,068	7,981
Clinical supplies		7,736	7,342	7,342	7,727
Infrastructure and non-clinical expenses		9,836	8,843	8,843	11,055
Payments to other health service providers	4b	49,985	55,222	55,222	48,868
Other operating expenses	4c	2,514	648	648	1,069
Finance costs	6b	732	1,364	1,364	713
Capital charge	7	772	1,140	1,140	753
Total expenses		140,908	140,177	140,177	138,118
Net Surplus/(deficit)	15	(1,047)	**(1,000)**	**-**	**(1,087)**
Other comprehensive revenue & expenses					
Gain/(losses) on revaluation of land and buildings	15	2,513	-	-	-
Other changes recognised directly in equity (impairment)	15	-	-	-	-
Total other comprehensive revenue & expenses		2,513	-	-	-
Total comprehensive revenue & expenses		**1,466**	**(1,000)**	**-**	**(1,087)**

The original Annual Plan budget for the West Coast DHB was a break even position which was submitted in the Statement of Intent and is shown as the 'Original Budget' column. However the Annual Plan was only approved by the Minister of Health after a reduction in transitional funding of $1m was incorporated, this is reflected in the 'Amended Budget' column.

STATEMENT OF CHANGES IN NET ASSETS/EQUITY

For the year ended 30 June 2015

in thousands of New Zealand dollars

	Note	2015 Actual	2015 Revised Budget	2015 Original Budget	2014 Actual
Balance at 1 July		10,097	10,084	10,084	10,152
Total comprehensive revenue & expenses		1,466	(1,000)	-	(1,087)
Owner transactions					
Capital contributions from the Crown		1,000	19,000	18,000	1,100
Repayment of capital to the Crown		(67)	(68)	(68)	(68)
Balance at 30 June	15	**12,496**	**28,016**	**28,016**	**10,097**

This statement is to be read in conjunction with the Notes to the Financial Statements

STATEMENT OF FINANCIAL POSITION

As at 30 June 2015

in thousands of New Zealand dollars

	Note	2015 Actual	2015 Revised Budget	2015 Original Budget	2014 Actual
Assets					
Current assets					
Cash and cash equivalents	13	5,718	10,068	10,068	7,483
Debtors and other receivables	12	11,099	4,218	4,218	8,786
Inventories	10	984	1,100	1,100	1,010
Patient and restricted funds	22	70	60	60	61
Assets held for sale	20	136	136	136	136
Total current assets		18,007	15,582	15,582	17,476
Non-current assets					
Property, plant and equipment	8	28,250	72,325	72,325	27,069
Intangible assets	9	1,575	1,211	1,211	1,681
Other investments	11	-	567	567	80
Total non-current assets		29,825	74,103	74,103	28,830
Total assets		**47,832**	**89,685**	**89,685**	**46,306**
Liabilities					
Current liabilities					
Borrowings	16	3,250	3,250	3,250	3,750
Creditors and other payables	18	9,368	7,248	7,248	10,587
Employee entitlements and benefits	17	8,797	9,081	9,081	8,468
Patient and restricted trust funds	22	63	60	60	61
Total current liabilities		21,478	19,639	19,639	22,866
Non-current liabilities					
Borrowings	16	11,195	39,195	39,195	10,695
Employee entitlements and benefits	17	2,663	2,835	2,835	2,648
Total non-current liabilities		13,858	42,030	42,030	13,343
Total liabilities		**35,336**	**61,669**	**61,669**	**36,209**
Net Assets/Equity					
Contributed Capital	15	71,694	89,693	88,693	70,761
Revaluations	15	22,082	19,569	19,569	19,569
Accumulated surpluses/(deficits)	15	(81,319)	(81,285)	(80,285)	(80,272)
Trust funds	15	39	39	39	39
Total equity		12,496	28,016	28,016	10,097
Total equity and liabilities		**47,832**	**89,685**	**89,685**	**46,306**

STATEMENT OF CASH FLOWS

For the year ended 30 June 2015

in thousands of New Zealand dollars

	Note	2015 Actual	2015 Revised Budget	2015 Original Budget	2014 Actual
Cash flows from operating activities					
Cash receipts from Ministry of Health, patients and other revenue		125,754	138,589	138,589	132,678
Cash paid to suppliers		(60,581)	(73,231)	(73,231)	(67,286)
Cash paid to employees		(64,215)	(60,505)	(60,505)	(62,065)
Interest received		517	588	588	608
Interest paid		(668)	(1,364)	(1,364)	(781)
Goods and services tax (net)		210	-	-	(238)
Capital charge paid		(772)	(1,140)	(1,140)	(897)
Net cash flow from operating activities	14	245	2,937	2,937	2,019
Cash flows from investing activities					
Receipts/(Purchase) of investments		595	(402)	(402)	(80)
Purchase of property, plant and equipment		(3,135)	(48,740)	(48,740)	(2,054)
Purchase of intangible assets		(3)	-	-	(506)
Net cash flow from investing activities		(2,543)	(49,142)	(49,142)	(2,640)
Cash flows from financing activities					
Capital contributions from the Crown		1,101	19,000	19,000	-
Repayment of capital to the Crown		(68)	(68)	(68)	(68)
Drawdown of loans		-	28,000	28,000	2,000
Repayment of loans		(500)	-	-	-
Net cash flow from financing activities		533	46,932	46,932	1,932
Net increase /(decrease) in cash and cash equivalents		(1,765)	727	727	1,311
Cash and cash equivalents at the start of the year		7,483	9,341	9,341	6,172
Cash and cash equivalents at the end of year	14	**5,718**	**10,068**	**10,068**	**7,483**

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

NOTES TO THE FINANCIAL STATEMENTS

or the year 30 June 2015

1 Statement of accounting policies

Reporting entity

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

West Coast DHB is a public benefit entities (PBEs) for financial reporting purposes.

West Coast DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the West Coast community. West Coast DHB does not operate to make a financial return.

The financial statements of West Coast DHB are for the year ended 30 June 2015 and were authorised for issue by the Board on 30 October 2015.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

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

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There were no material adjustments arising on transition to the new PBE accounting standards. Previously the West Coast DHB reported under the New Zealand equivalent to International Financial Reporting Standards.

Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: land, buildings, fixtures and fittings.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value.

Functional and presentation currency

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand dollars. The functional currency of West Coast DHB is NZD.

Changes in accounting policies

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

Significant accounting policies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 DHB 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 date the West Coast DHB 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 DHB 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.

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 DHB's cash management are included as a component of cash and cash equivalents for the purposes of the statement of cash flows.

Equity investments

Equity

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

- Contributed capital;
- Revaluation reserve; and
- Accumulated surpluses/ (deficits).

Revaluation reserve

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

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.

Impairment

The carrying amounts in the West Coast DHB'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 re-valued 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 re-valued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a re-valued 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.

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

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 DHB on 1 January 2001. Accordingly, assets were transferred to the West Coast DHB 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.

At each balance date West Coast DHB reviews the useful lives and residual values of all of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires West Coast DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by West Coast DHB, advance in medical technology, and expected disposal proceeds from the future sale of the assets. Any adjustments are disclosed in note 8.

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. Canterbury DHB 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.

Revaluation of land, buildings, fixtures and fittings
Land, buildings, fixtures and fittings are re-valued 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 balance 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 DHB are stated at cost less accumulated amortisation and impairment losses.

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

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

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

	Years
Acquired computer software	2 - 10

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

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

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

Bonuses
The West Coast DHB 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 date.

Sabbatical leave
The West Coast DHB'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 DHB 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 23.

Leased assets

Finance leases
Leases which effectively transfer to the West Coast DHB 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 DHB is expected to benefit from their use.

The Public Finance Act 1989 requires DHBs 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 original Annual Plan budget for the West Coast DHB was a break even position. However, due to a reduction in the level of transitional funding from the Ministry of Health, the Annual Plan was amended to a $1m deficit. The budget figures shown are the amended budget which was approved by the Board and published in the 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 DHB for the preparation of these financial statements.

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

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

The 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 DDHB 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 DHB 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 DHB 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 DHB, 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 DHB 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 DHB 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 Patient care revenue

	2015 Actual	2014 Actual
Ministry of Health population based funding	119,700	117,461
Inter district flows	1,497	1,615
Ministry of Health other contracts	7,538	7,309
Accident Compensation Corporation	2,093	1,806
Other Patient Related Revenue	3,313	3,030
West Coast Primary Health Organisation	4,558	4,573
	138,699	**135,794**

3 Other operating revenue

	2015 Actual	2014 Actual
Donations received	4	55
Donated assets	58	27
Rental revenue	184	176
Training and Development	123	-
Home Based Support Services	73	-
Pharmacy	45	-
Insurance	7	-
Other	151	371
	645	**629**

4 (a) Outsourced services

	2015 Actual	2014 Actual
Outsourced personnel and services		
Medical and nursing services	5,452	6,194
Allied health services	(2)	21
Other services	1,805	1,766
	7,255	**7,981**

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

	2015 Actual	2014 Actual
Personal health and Maori health services	22,626	22,660
Mental health services	2,994	2,988
Public health services	363	417
Disability support services	8,516	8,317
Inter district patient outflows	15,486	14,486
	49,985	**48,868**

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	2015 Actual	2014 Actual
Impairment of debtors	12	27	-
Loss on disposal of property, plant and equipment		70	55
Audit fees (for the audit of the financial statements)		104	102
Audit related fees for assurance and related services (Internal and Quality Audits)		105	97
Board and advisory members fees		180	229
Operating lease expenses		626	154
Other		1,402	432
		2,514	**1,069**

5 Employee benefit costs

	2015 Actual	2014 Actual
Wages, salaries and other personnel costs	55,844	53,771
Contributions to defined contribution schemes	1,352	1,401
(Decrease)/increase in liability for employee entitlements	344	(21)
Restructuring expenses	300	326
	57,840	**55,477**

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

6 (a) Interest revenue

	2015 Actual	2014 Actual
Interest revenue	**517**	**608**

(b) Finance costs

	2015 Actual	2014 Actual
Interest expense	**732**	**713**

7 Capital charge

	2015 Actual	2014 Actual
Capital charge	**772**	**753**

The West Coast DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the period ended 30 June 2015 was 8% (2014: 8%).

8 Property, plant and equipment

14/15 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 2014	6,085	17,465	24,302	340	74	48,266
Additions	-	21	1,796	-	644	2,461
Disposals/transfers	-	-	(1,599)	-	-	(1,599)
Revaluations and impairments	514	1,997	-	4	-	2,515
Transfer from non-current assets held for sale	-	-	-	-	-	-
Work in progress allocated	-	-	-	-	-	-
Balance at 30 June 2015	**6,599**	**19,483**	**24,499**	**344**	**718**	**51,643**
Depreciation						
Balance at 1 July 2014	-	(3,586)	(17,317)	(294)	-	(21,197)
Depreciation charge for the year	-	(1,913)	(1,802)	(7)	-	(3,722)
Transfer to non-current assets held for sale	-	-	1,075	-	-	1,075
Disposals	-	-	451	-	-	451
Revaluations	-	-	-	-	-	-
Balance at 30 June 2015	**-**	**(5,499)**	**(17,593)**	**(301)**	**-**	**(23,393)**

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)**

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 2014	6,085	13,879	6,985	46	74	27,069
At 30 June 2015	**6,599**	**13,984**	**6,906**	**43**	**718**	**28,250**

Valuation

Freehold property and plant was re-valued 30 June 2015 by Preston Rowe Paterson (registered valuers). Greymouth, Westport and Reefton Hospitals, Fox Glacier Clinic and Ngakawau Clinic were valued on the basis of 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 15).

Impairment

Engineering reviews of Grey Base buildings last financial year identified structures which are earthquake prone. For these structures, the West Coast DHB has considered whether their carrying value exceeded their recoverable amount. As a result, the DHB recognised at 30 June 2012 a $2.6m asset impairment. As at 30 June 2015, no further impairment was considered necessary.

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

9 Intangible assets

	2015 Actual	2014 Actual
Software		
Cost		
Opening balance	4,152	3,761
Additions	2	447
Disposals	(13)	(56)
Closing balance	4,141	4,152
Amortisation		
Opening balance	(2,636)	(1,949)
Amortisation charge for the year	(516)	(637)
Disposals	13	(50)
Closing balance	(3,139)	(2,636)
Health Benefits Limited	573	165
Carrying amounts	1,575	1,681

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 2015. There has been no change since last year.

The West Coast DHB has contributed $573,000 (2014: $165,000) to Health Benefits Limited (HBL) in relation to the Finance, Procurement and Supply Chain (FPSC) Programme in 2015. 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.

As from 1 July 2015, the operations of Health Benefits Limited transferred under the Health Sector (Transfers) Act 1993 to a new company called NZ Health Partnerships Ltd.

10 Inventories

	2015 Actual	2014 Actual
Pharmaceuticals	207	131
Surgical and medical supplies	759	865
Other supplies	18	14
	984	**1,010**

There were no write downs of inventories or reversal of prior year write-downs during the year (2014: $0). The amount of inventories recognised as an expense during the year ended 30 June 2015 was $1.967m (2014: $1.77m).

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

	2015 Actual	2014 Actual
Non-current		
Equity instrument	-	-
Other term deposits	-	80
Total investments	**-**	**80**

12 Debtors and other receivables

	Note	2015 Actual	2014 Actual
Trade receivables	21	1,857	1,380
Ministry of Health receivables		2,466	2,743
Other Crown receivables		6,020	3,857
Accrued revenue		407	433
Prepayments		349	373
	21	**11,099**	**8,786**

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.

Trade receivables, prepayments and other receivables are from exchange revenue transactions. Receivables from the Ministry of Health are a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in Receivables from the Ministry of Health is $1M ($1.1M 2014)

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

	Note	2015 Actual	2014 Actual
Balance 1 July		30	81
Receivables written off during the year		(3)	(51)
Impairment reversed		(2)	-
Additional provision made during the year	4c	27	-
Closing balance 30 June		**52**	**30**

13 Cash and cash equivalents

	Note	2015 Actual	2014 Actual
Bank balances and call deposits		5,718	7,476
Term deposits less than 3 months		-	7
Cash and cash equivalents in the statement of cash flows	21	**5,718**	**7,483**

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

The West Coast DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts (not included in the above) and interest earned is allocated to the individual patients (see note 22.)

14 Reconciliation of net surplus/(deficit) for the period with net cash flows from operating activities

	2015 Actual	2014 Actual
Deficit for the period	(1,047)	(1,087)
Add back non-cash items:		
Depreciation and amortisation expense	4,238	4,475
Remove non-cash revenue:		
Donated assets	(58)	(27)
Add back other items:		
Equity receivable	1,000	1,100
Movements in working capital:		
(Increase)/decrease in debtors and other receivables	(2,313)	(4,818)
(Increase)/decrease in inventories	26	114
Increase/(decrease) in creditors and other payables	(1,945)	2,283
Increase/(decrease) in employee benefits	344	(21)
Net movement in working capital	(3,888)	(2,442)
Net cash inflow/(outflow) from operating activities	**245**	**2,019**

15 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 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**
Balance at 1 July 2014	70,761	19,569	39	(80,272)	10,097
Surplus/(deficit) for the year				(1,047)	(1,047)
Capital contributions from the Crown	1,000				1,000
Repayment of capital to the Crown	(67)				(67)
Movement in revaluation of land		860			860
Movement in revaluation of buildings, fixtures and fittings		1,653			1,653
Movement in revaluation of building, fixtures and fittings due to impairment					
Balance at 30 June 2015	**71,694**	**22,082**	**39**	**(81,319)**	**12,496**

The West Coast DHB'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. The West Coast DHB's land, buildings, fixtures and fittings were revalued as at 30 June 2015 by Preston Rowe Paterson (registered valuers). Greymouth, Westport and Reefton Hospitals as well as Fox Glacier Clinic and Ngakawau Clinic were valued on the basis of 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	2015 Actual	2014 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 revenue and expenses. 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.

16 Borrowings

Secured loans

The West Coast DHB has secured loans with the Ministry of Health.

	Note	2015 Actual	2014 Actual
Non-current			
Ministry of Health	21	11,195	10,695
		11,195	**10,695**
Current			
Ministry of Health	21	3,250	3,750
		3,250	**3,750**

The Ministry of Health loans are issued at fixed rates of interest. The carrying amounts of borrowings approximate their fair values. The details of terms and conditions are as follows:

Interest rates
The average interest rates on the DHB's borrowing for the year are as follows:

	Note	2015 Actual	2014 Actual
Repayable as follows:			
Within one year		3,000	3,750
Weighted average effective interest rate		4.75%	*6.29%*
Later than one year but not more than five years		5,195	3,500
Weighted average effective interest rate		4.97%	*4.44%*
Later than five years		6,250	7,195
Weighted average effective interest rate		3.98%	*5.08%*
	21	**14,445**	**14,445**
Total loan facility limits			
Ministry of Health		14,445	14,445
		14,445	**14,445**

Security
The security of the Ministry of Health loans is guaranteed by is an agreement with the Ministry of Health that ensure that without their prior written consent West Coast DHB cannot perform any of the following actions:

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any of its assets except disposals at full value in the ordinary course of business.

17 Employee entitlements and benefits

	2015 Actual	2014 Actual
Non-current liabilities		
Liability for long-service leave	623	622
Liability for sabbatical leave	65	73
Liability for retirement gratuities	1,975	1,953
	2,663	**2,648**
Current liabilities		
Liability for long-service leave	232	173
Liability for retirement gratuities	570	622
Liability for annual leave	3,867	3,901
Liability for other leave	1,463	1,234
Liability for sick leave	92	141
Liability for continuing medical education/ sabbatical leave	874	900
Salary and wages accrued	1,699	1,497
	8,797	**8,468**

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 2015.

18 Creditors and other payables

	Note	2015 Actual	2014 Actual
Trade payables		7,498	9,072
ACC levy payable		544	381
GST and PAYE tax payable		1,303	1,110
Revenue in advance		23	24
	21	**9,368**	**10,587**

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.

All of the Creditors and Other Payables balances are derived from exchange transactions.

19 Commitments

	2015 Actual	2014 Actual
Total capital commitments at balance date	**499**	**1,716**
Non-cancellable operating lease commitments		
Not more than one year	126	114
One to two years	54	49
Two to three years	61	55
Total non-cancellable operating lease and supply commitments	**240**	**218**

The West Coast DHB currently leases the premises of Greymouth Medical Centre, office space and other short term accommodation. The other leases are for one to three years with rights of renewal.

20 Non-current assets held for sale

The West Coast DHB 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 (2014: $136,650).

21 Financial instruments

The West Coast DHB 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.

Market risk

Price risk
Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. West Coast DHB is exposed to debt securities price risk on its investments. This price risk arises due to market movements in listed debt securities. The price risk is managed by diversification of West Coast DHB's investment portfolio in accordance with the limits set out in West Coast DHB's investment policy.

Currency risk
Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. WCDHB has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2015 (2014: nil)

Interest rate risk
The interest rates on investments is disclosed in note 11 and on borrowings in note 16.

Fair value interest rate risk
Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. Borrowing issued at fixed rate and term deposits held at fixed rates expose the West Coast DHB to fair value interest rate risk.

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 DHB 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 26).

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry, which comprises 22% (2014: 31%) of the debtors of the West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHB) total reliance on Government debtors is 76% (2014: 75%). 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 receivables at year end is as follows:

Trade Receivables

	Note	Gross Receivable 2015	Impairment 2015	Net 2015	Gross Receivable 2014	Impairment 2014	Net 2014
Due 0-30 days		9,939	-	9,939	8,090	-	8,090
Past due 31-60 days		56	-	56	154	-	154
Past due 61-90 days		22	-	22	90	-	90
Past due more 90 days		785	(52)	733	109	(30)	79
Total Gross Receivables	12	**10,802**	**(52)**	**10,750**	**8,443**	**(30)**	**8,413**

Trade receivables are due from patients and external parties to whom the West Coast DHB 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 DHBs 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 2015 was 3.94% (2014: 4.55%).

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 the 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

	2015 Actual	2014 Actual
Cash		
AA-	(129)	(112)
Term Deposits - Patient and Restricted Funds		
AA-	70	80
Total Cash and Term Deposits	**(59)**	**(32)**

Counterparties without credit rating

	2015 Actual	2014 Actual
Balance with Health Benefits Limited		
Existing counterparty with no defaults in the past	5,847	7,595
Total balance with Health Benefits Limited	**5,847**	**7,595**
Debtors and other receivables		
Existing counterparty with no defaults in the past	11,099	8,786
Total debtors and other receivables	**11,099**	**8,786**

Liquidity risk

Liquidity risk represents the West Coast DHB's ability to meet its contractual obligations. The West Coast DHB evaluates its liquidity requirements on an ongoing basis. The Board received deficit support from the Ministry of Health during the year as it did not generate sufficient cash flows from its operating activities to meet its obligations from financial liabilities in the year ended 30 June 2015. The Board made an application for equity (deficit support) based on the approved District Annual Plan for 2015/16 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	Less than 1 year	1-2 years	2-5 years	More than 5 years
2015						
Secured Ministry of Health loans	14,445	14,445	3,000	250	4,945	6,250
Creditors and other payables	9,368	9,368	9,368			
Total	**23,813**	**23,813**	**12,368**	**250**	**4,945**	**6,250**
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**	**14,337**	**3,250**	**250**	**7,195**

Fair values
Fair values of financial assets and liabilities with standard terms and conditions and trade in an active market are determined with reference to quoted market prices (Level 1).

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

	Note	Carrying amount 2015 Actual	Fair value 2015 Actual	Carrying amount 2014 Actual	Fair value 2014 Actual
Other investments	11	-	-	80	80
Patient and Restricted Funds	22	70	70	61	61
Debtors and other receivables	12	11,099	11,099	8,786	8,786
Cash and cash equivalents	13	5,718	5,718	7,483	7,483
		16,887	**16,887**	**16,410**	**16,410**
Secured loans	16	14,445	15,169	14,445	14,924
Creditors and other payables	18	9,368	9,368	10,587	10,587
		22,813	**24,537**	**25,032**	25,511
Unrecognised (losses)/gains		**-**	**724**	**-**	**479**

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	2015 Actual	2014 Actual
Loans and receivables			
Cash and cash equivalents	13	5,718	7,483
Other investments	11	-	80
Patient and Restricted Funds	22	70	61
Debtors and other receivables	12	11,099	8,786
		16,887	**16,410**
Financial assets at fair value through other comprehensive revenue			
Investments-equity instruments	11	-	-
		-	**-**
Financial liabilities			
Creditors and other payables	18	9,368	10,587
Borrowings-secured loans	16	14,445	14,445
		23,813	**25,032**

22 Patient and restricted funds

The West Coast DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts and any interest earned is allocated to the individual patient balances.

	2015 Actual	2014 Actual
Opening balance patients deposits	54	54
Monies received	8	-
Interest earned	1	-
Payments made	-	-
Closing balance	**63**	**54**

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

	2015 Actual	2014 Actual
Opening balance restricted funds	7	6
Monies received	-	-
Interest earned	-	1
Payments made	-	-
Closing balance	**7**	**7**

23 Contingencies

Contingent liabilities

Superannuation schemes

The West Coast DHB 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 DHB 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 DHB could be responsible for an increased share of the deficit.

Contingent assets
The West Coast DHB has no contingent assets (2014: nil).

24 Related parties

The West Coast DHB is a wholly owned entity of the Crown.

Significant transactions with government related entities
The West Coast DHB has received funding from the Crown, ACC and other government entities of $134.17m to provide health services in the West Coast area for the year ended 30 June 2015 (2014: $131.28m).

Revenue earned from other DHBs for the care of patients domiciled outside the West Coast DHB's district as well as services provided to other DHBs amounted to $1.53m for the year ended 30 June 2015 (2014: $1.64m). Expenditure to other DHBs for the care of patients from the West Coast DHB's district and services provided from other DHBs amounted to $18.00m for the year ended 30 June 2015 (2014: $16.96m).

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

The West Coast DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2015 totaled $2.244m (2014: $2.86m). 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

	2015		2014	
	FTE	Actual	FTE	Actual
Short-term employee benefits-executive management	5	717	5	757
Post-employment benefits		12		20
		729		**777**

The executive management team consisted of 5 members (2014: 5) employed by West Coast DHB and a further 6 members, including the Chief Executive, who were employed by Canterbury DHB (2014: 6). The key management personnel services provided by the Chief Executive and other key management personnel are provided to West Coast DHB under contract by Canterbury DHB and are invoiced accordingly- 2015: $300k (2014: $300k). For the year under review, no executive management personnel were Board members (2014: nil). Short-term employee benefits include all salary, leave payments and lump sum payments. Post-employment benefits are West Coast DHB contributions to superannuation and kiwi saver schemes.

25 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. An EOI process has been completed as at balance date and the Implementation Business Case is being developed.
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 2016; 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 2015 which could have a material impact on the information in West Coast DHB's financial statements.

26 Bank facility

West Coast DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one 12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For West Coast DHB that equates to $5.9M.

As from 1 July 2015, the operations of Health Benefits Limited transferred under the Health Sector (Transfers) Act 1993 to a new company called NZ Health Partnerships Ltd.

27 Major variances to budget

The financial result for the full financial year to June 2015 is a deficit of $1.047m, which is marginally above the budgeted deficit of $1m.

In addition, a one off property revaluation of $2.513m across Land and Buildings (including fit out) based on an external valuation has been classified as comprehensive revenue in June 2015.

Employee Benefit Costs above budget due to use of locums and agency staff above the expectations set in the budget to manage and maintain service through periods of leave and vacancies from staff turnover.

Facilities, IT and telecommunications costs make up the bulk of the infrastructure and non-clinical expenses category and is generally related to the realisation of the regional IT development programmes and service reviews.

Finance costs and Capital charges are below the 2015 Revised budget as the loans and equity drawdowns anticipated in the 2014-15 Annual Plan for the Greymouth hospital redevelopment have not eventuated in the timeline originally anticipated.

28 Adjustments arising on transition to the new public benefit entity (PBE) accounting standards

Reclassification adjustments
There have been no reclassifications on the face of the financial statements in adopting the new PBE accounting standards.

Recognition and measurement adjustments
There have been no recognition and measurement adjustments in adopting the new PBE accounting standards.

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 2015. 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.

	2015 Actual	2015 Revised Budget	2015 Original Budget
Revenue			
Prevention	3,665	3,261	3,261
Early Detection and Management	36,592	36,504	36,504
Intensive Assessment and Treatment	77,074	77,080	78,080
Rehabilitation and Support	22,530	22,332	22,332
Total Revenue	139,861	139,177	140,177
Expenditure			
Prevention	3,791	2,998	2,998
Early Detection and Management	36,178	36,496	36,496
Intensive Assessment and Treatment	79,066	78,306	78,306
Rehabilitation and Support	21,873	22,377	22,377
Total Expenditure	140,908	140,177	140,177
Surplus/ (Deficit)	**(1,047)**	**(1,000)**	**-**

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

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 2015

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

Opinion on the financial statements and the performance information

We have audited:

- the financial statements of the Health Board on pages 39 to 71, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expenses, statement of changes in net assets/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 6 to 14, the statement of service performance on pages 15 to 26 and a statement of revenue and expenditure by output class on page 72.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2015; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Tier 1 public benefit entity accounting standards.

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

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 practicable 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 performance information of the Health Board for the year ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effects of the matters described above, the performance information of the Health Board on pages 6 to 14, pages 15 to 26, and page 72:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 October 2015. 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 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 the 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 the performance information. We were unable to determine whether there are material

misstatements in the statement of performance 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 the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board's financial statements and performance information in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand and Tier 1 public benefit entity accounting standards;
- present fairly the Health Board's financial position, financial performance and cash flows; and
- present fairly the Health Board's performance.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

The Board is 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 the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

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.

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