West Coast DHB

ANNUAL REPORT 2015/16

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Board Members
Peter Ballantyne, Chair
Kevin Brown
Warren Gilbertson (*appointed 19 November 2015)*
Helen Gillespie
Michelle Lomax
Peter Neame
Sharon Pugh
Elinor Stratford
Joseph Thomas
Francois Tumahai *(appointed 21 April 2016)*
John Vaile
Susan Wallace *(term ended 20 April 2016)*

Chief Executive
David Meates

Registered Office
West Coast DHB
Grey Base Hospital
High Street
Greymouth

Auditor
Audit New Zealand on behalf of the Auditor-General

Banker
Westpac Banking Corporation

Report from the Chair and Chief Executive

Focusing on people first

Annual reports are often full of numbers – have we met our targets? How well have we done? Did we manage our finances? But what these numbers really mean to us is a measure of how we are doing as a health system. Are West Coasters better off, in terms of their health, as a result of the work we're doing?

Our vision is to ensure people have the right care, in the right place and as close to their homes as is possible, and in a timely fashion. To achieve that, we need to continue to work together so that our patients, clients, neighbours, friends and whanau are being treated with dignity and respect. We need to value their time and collaborate so they do not have to tell their health stories over and over to different people.

We continue to live with the challenges of our small population. We don't have the critical mass to offer some full-time services, and we rely on our transalpine partners (Canterbury DHB) to either support the delivery of these services on the West Coast, or provide treatment for Coasters in Canterbury. We have continued to have challenges in recruiting to West Coast positions, particularly for GPs. We have, however, had success in other specialties.

In Maternity Services, our transformative approach has been paying off, and a recent one year review since the implementation of our changes has shown a vast improvement in outcomes for mothers and babies, and a ready supply of midwives keen to work on the West Coast. Improved communications and education, extra appointments in Maternity Services, and the implementation of sustainability packages for the self-employed midwives have all contributed to these successes.

Integrating Care: A health care home and a single point of referral for complex care

We've made some inroads into further integrating care. A successful nurse-led collaborative project with Poutini Waiora, Community and Public Health and primary practice offering spirometry clinics targeting Maori in Buller is being expanded and replicated across the Coast.

We are involving more and more community members in our integrated family health services workstreams. Already they are helping us plan services in Reefton and Buller, and Grey is next.

The Consumer Council continues to advise us about how well our work focuses on our patients and clients, by reviewing our processes, policies and publications.

Our diversional therapist in Buller has had some great success in working with formerly isolated folk in the community, involving them in outings and activities that will help to keep them connected. There are positive spin-offs in finding out about any health issues at an early stage, and keeping these mostly older folk active.

This work is intrinsically linked to our direction of travel for older person's health, to match the New Zealand trend for older folks to want to stay at home, and marked decreases in rest home level care. During the year we closed the DHB's Kynnersley Home facility for rest home level care in Buller. The aged residential care provider in Buller, O'Conor Home, is increasing its capacity to provide hospital and dementia level care, including respite care, for the Buller community. The DHB's Dunsford Ward hospital level care will also be transitioned to close as the O'Conor facilities are completed and can provide adequate beds.

Supporting this direction of travel, a Falls Prevention physiotherapist is working across the Coast with the DHB's Complex Clinical Care Network (CCCN). Clinical nurse specialists in the following areas work directly with general practice and in the community to provide care, support and education: Cardiac, Respiratory, Diabetes, Palliative, Oncology, Stroke, and Faster Cancer Treatment.

A new Maori Health Clinical Assessor working with the CCCN is working in collaboration with the Maori communities on the Coast to improve outcomes for Maori with long term conditions.

In mental health much work has been underway to improve crisis responsiveness services and ensure service delivery and care is contemporary. We're working on the integration of primary and secondary services and a move to more community-based care. This is ongoing.

Sustaining Care: Transalpine services and supporting health professionals

The West Coast localised Health Pathways that give guidance to our clinicians about the appropriate care and referrals have increased in the past year to 654. While we have further Health Pathways to document, this is a pleasing achievement.

We have instigated a unique Coast arrangement to provide clinical leadership for our West Coast, by appointing three Medical Directors each with different oversights.

The three new clinical leadership roles are:

- Medical Director | Medical Council, Legislative Compliance and National Representation
- Medical Director | Patient Safety and Outcomes
- Medical Director | Facilities Development

The roles provide an opportunity to lead and engage stakeholders; develop, enable and support the delivery of policy and direction; and influence and enhance medical capability, patient safety and outcomes and facilities development.

In South Westland we ran a trial using Homecare Medical Ltd to provide greater access to booking general practice appointments, and reduce the after-hours burden on our staff. The DHB attended many community meetings to discuss health services in South Westland, and work through any issues raised during the trial. We now have a better service available for our patients and rostered time off for our staff.

Connecting Care: Integrated information systems

Collaboration with Canterbury DHB's decision support has enabled new data tools for hospital service managers on the West Coast.

The series includes a dashboard each for inpatients and emergency activity, as well as hospital capacity viewable at a glance, including in the emergency department.

Telehealth continues to provide patients with remote access to care where appropriate, and we've been working with our clinicians to increase its use, to save our patients time and money, and reduce delays for patients in being able to access care.

Joined-up Care: Settings and fit-for-purpose facilities

After many months of serious planning and attention to detail led by our clinicians, building work finally started on the new Grey Base Hospital and adjoining Integrated Family Health Centre.

The Minister of Health recently approved an extra $9.7 million to build what is now a $77.8 million facility, opening in mid-2018.

The 8,500 square metre facility adjacent to the current Grey Base Hospital includes 56 in-patient beds, three operating theatres, and an integrated family health centre to support the delivery of primary healthcare services. It will also house and support the delivery of other clinical services including a 24/7 emergency department, critical care unit, acute and planned medical and surgical services, maternity services, and outpatient care.

Work on the new Buller facilities is progressing with the Ministry of Health and the Hospital Redevelopment Partnership

Group continuing to work with our clinicians on design and financing options.

Health targets: Commitments to the Crown

Every quarter the Crown asks us to report back against a series of health targets.

We continue to regularly meet targets around provision of smoking cessation messages and support, shorter stays for patients in our emergency department, ensuring the people who need them have heart and diabetes checks, and our targets for elective surgery.

The large numbers of opt-offs and declines from those who choose not to be immunised remains at odds with the national targets. However we do very nearly reach 100% of those in the target groups who choose to be immunised.

An excellent initiative in Reefton with primary and secondary services working together to provide a one stop shop with flu immunisations and general health checks for locals. We have also achieved better staff uptake this year for flu immunisations which are provided by the DHB.

We have had a better result in terms of adverse outcomes for patients as evidence in numbers of cases referred to the Office of the Health and Disability Commissioner (HDC). In the six months from July 2015 to end of December 2015 we had no complaints, and just one in the next six months to the end of June 2016. We continue to investigate, analyse and act upon any concerns raised through our internal Safety1st online incident reporting system, and work on staff education to improve outcomes for patients as a result of any other internal or external investigations and/or complaints.

Clinically and financially sustainable care: A clear plan and commitment

Over the past year among other capital expenditure, we have installed a new endoscopy tower and purchased new colonoscopies and gastroscopes for the Grey Base Hospital. Upgrading our technologies is essential in continuing to provide good treatment and health services for the people of the West Coast.

We are trying to ensure we carefully balance the requirement for equipment with our upcoming transition to new facilities, so older equipment can be maintained on the current site where possible until our transition to the new Grey Base Hospital allows for the purchase of new equipment that can be installed directly into the new facilities. That way we avoid the costs around having to install some finely calibrated and heavy equipment twice.

Through careful and prudent management of our costs and income, we have finished our financial year on budget. This is no mean feat with the various challenges that present over the course of each year.

We would like to thank all staff for their conscientiousness and commitment to providing excellent healthcare services across the Coast.

Peter Ballantyne
Chair
28 October 2016

David Meates
Chief Executive
28 October 2016

Measuring Our Progress

Like all DHBs the West Coast DHB is expected to deliver against the national health sector goals: '*All New Zealanders lead longer, healthier and more independent lives*' and '*the health system is cost effective and supports a productive economy*'. We are also expected to meet our objectives under the New Zealand Public Health and Disability Act to '*improve, promote and protect the health of people and communities*'.

As part of our accountability we need to demonstrate whether we are meeting these goals and expectations. There is no single indicator that will demonstrate the impact of the work we do. Instead, the five South Island DHBs have identified a core set of fifteen population health and service performance measures that will provide an insight into how well our health system is performing.

Tracking our performance against these indicators will enable us to evaluate our success in areas that are important to Government, our Board and our community.

Six of the identified measures are outcomes indicators, where success will be evident over the longer-term. As such, the aim is for a measurable change in health status over time, rather than a fixed target.

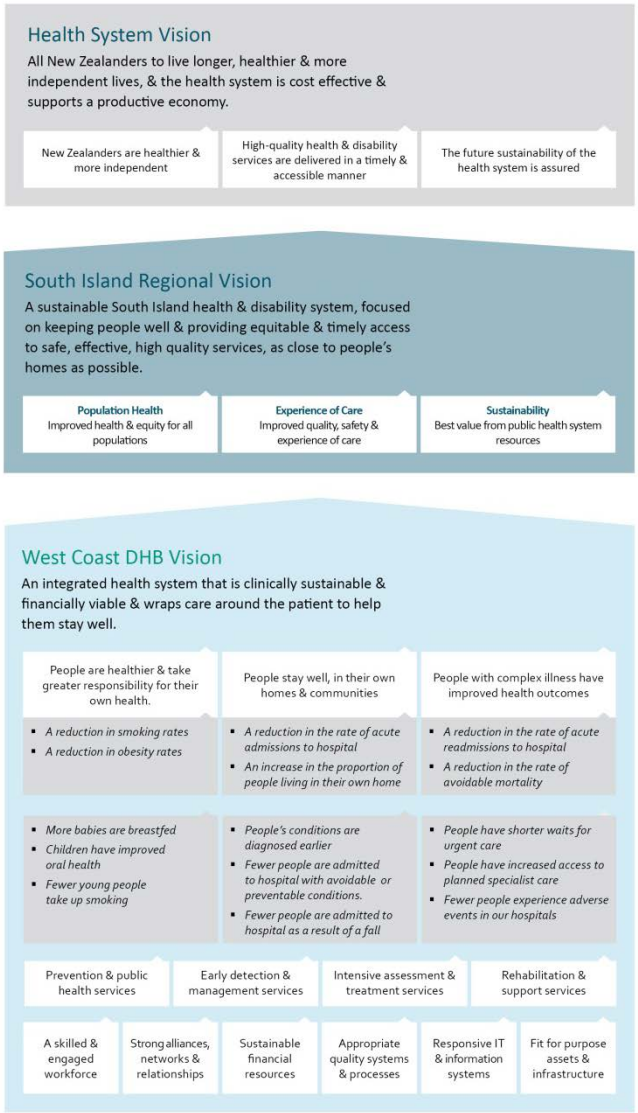
The remainder are seen as contributory measures, where our performance will have a measureable impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been identified as the main measures of performance.

We have set standards (or targets) for each of the contributory measures in order to evaluate our performance and determine whether we are moving in the right direction.

Results are presented in this Annual Report, alongside our Statement of Service Performance for 2015/16. Together they will help us to evaluate the quality and effectiveness of our service delivery and determine whether we are having a positive impact on the health and wellbeing of our population.

The fifteen performance measures selected were deliberately chosen from existing national reporting frameworks and data sources. This will enable regular monitoring and comparison with other DHBs, to give context to our performance.

The intervention logic is highlighted below, illustrating how we anticipate the services that we fund or provide (outputs) will impact on the health of our population, result in the longer-term outcomes desired and deliver on the expectations and priorities of Government.



Note: In the graphs presented over the following pages, the South Island result represents the regional performance and includes all five South Island DHBs – rather than presenting West Coast compared to the rest of the South Island. The same methodology applies to the national results.

Are We Making a Difference?

Objective 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 conditions such as diabetes, cancer and cardiovascular disease, which are major drivers of poor health and premature mortality (death) and account for significant pressure on health services. The likelihood of developing these long-term conditions increases with age, and as our population ages the demand for health services will grow. These conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with disparities in health outcomes across population groups.

Tobacco smoking, inactivity and poor nutrition are major contributors to the most prevalent long-term conditions. These are avoidable risk factors and can be reduced through supportive environments and improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will improve their quality of life and by improving the health status of our population, reduce avoidable demand for health services.

OVERARCHING OUTCOMES INDICATORS

Outcome: A reduction in smoking rates

The West Coast's smoking rates continue to decline. The latest NZ Health Survey found that 22.3% of our population smoke, moving slightly closer to the New Zealand population rate of 17.7%.

Our efforts are focused on two of the major risk factors, encouraging fewer young people to take up smoking and supporting current smokers to quit.

We continue to deliver ABC to reduce smoking rates. Over the past year 82% of smokers in primary care and 95% of smokers in our hospitals have been Asked their smoking status, provided with Brief advice and offered Cessation support.

Data source: National NZ Health Survey.[1]

Measure: Percentage of the population (15+) who smoke

Outcome: A reduction in obesity rates

West Coast obesity rates remain above the national average of 29.7%, however, the most recent NZ Health Survey suggests a slight drop to 31.8% which is a positive sign.

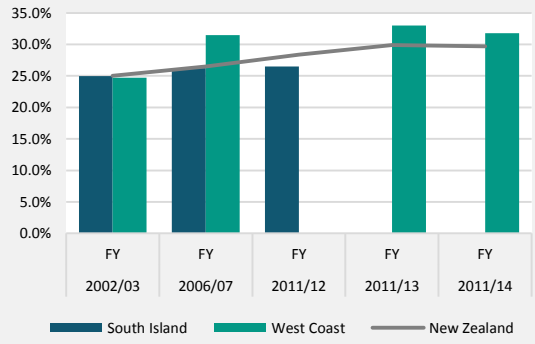
Local initiatives that encourage healthier diets and more physical activity include our Health Promoting Schools and Green Prescription programmes.

Green Prescription uptake is positive with 543 people accessing the service this year, and more than half (58%) of participants reporting they are more active 6-8 months later.

The DHB has also committed to achieving the new Raising Healthy Kids health target and will begin to track performance against this measure in 2016/17.[2]

Data source: National NZ Health Survey.[3]

Measure: Percentage of the population (15+) who are obese



[1] *The NZ Health Survey is completed by the Ministry of Health and since 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 unavailable by ethnicity. The 2013 Census (while not directly comparable) suggests smoking rates for Māori are improving, but are still high compared to the rest of the population - 34.3% of West Coast Māori (15+) identified as regular smokers, down from 41.4% in 2006.*

[2] *The new national health target aims to provide early intervention and healthy eating and activity support to children identified as obese at their B4 School Check. These children and their families will be given a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle advice.*

[3] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.*

IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

Impact: More babies are breastfed

Breastfeeding rates appear to have dropped slightly for the total population, having lifted slightly in the previous year. However, rates for Maori have continued to climb which is a positive result.

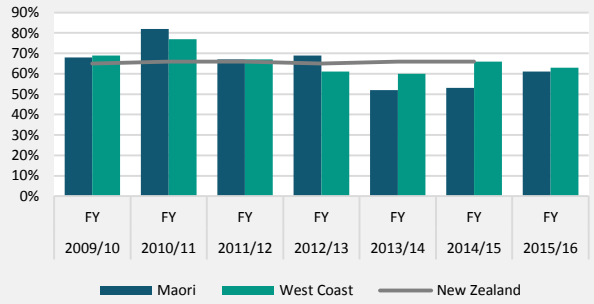
A range of services are provided to encourage and support women to breastfeed including peer support programmes and community based lactation support.

Uptake of the lactation support programme is high with 214 women accessing specialist advice in the community almost twice the uptake of two years ago (117).

Improving breastfeeding rates continues to be a key focus for the West Coast Alliance and in our Maori Health Plan.

Data source: Plunket via the Ministry of Health.[4]

Measure: Percentage of babies exclusively or fully breastfed at six weeks	2013/14	2014/15	2015/16 Target	2015/16 Result
	60%	66%	74%	63%



Impact: More children have improved oral health

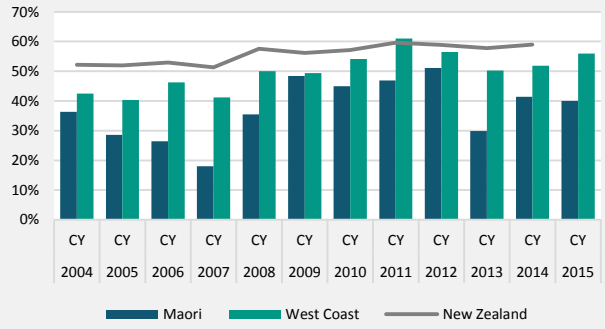
The percentage of five-year-olds caries-free (no holes or fillings) has continued to improve and we have reached target. Rates for Maori have remained fairly static.

Enrolment rates in our School and Community Dental Services have fluctuated over the last two years and the small number of children involved means these results are subject to a greater degree of variation.

However, improvements in the proportion of enrolled children being seen and examined on time will have a positive effect on outcomes in future years. Of the (87%) of children enrolled this year 90% were examined according to plan, compared to 86% in 2014/15.

Data source: DHB School & Community Dental Service.[5]

Measure: Percentage of five-year-olds caries free (no holes or fillings)	2013	2014	2015 Target	2015 Result
	50%	52%	56%	56%



Impact: Fewer young people take up tobacco smoking

The 2015 ASH survey continues to show a positive trend for the West Coast with 80% of Year 10 students (age 14) having never smoked.

This trend reflects the impact of supportive legislation and social environments combined with local initiatives such as Health Promoting Schools, smokefree public places (such as parks and marae) and training and advice for tobacco retailers to limit youth access to tobacco.

A continued decline in adult smoking rates will also be having a positive influence on these rates.

Data source: National Year 10 ASH Survey[6]

Measure: Percentage of 'never smokers' among Year 10 students	2013	2014	2015 Target	2015 Result
	82%	67%	>75%	80%

[4] *Provider data for breastfeeding is currently unable to be combined, so only performance data from Plunket (as the largest provider) is presented. While this covers the majority of babies, because the smaller local Well Child/Tamariki Ora providers target Māori and Pacific mothers—results for these ethnicities may be understated. The standard is set nationally as part of the national Well Child Quality Framework.*

[5] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.*

[6] *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. The number of West Coast students participating in the annual survey is around 200-220 as a result these small numbers can lead to fluctuations between years —for more detail see www.ash.org.nz.*

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

WHY IS THIS OUTCOME A PRIORITY?

When people are supported to stay well and can access the care they need closer to home and in the community, they are less likely to need hospital-level or long-stay interventions. This is not only a better experience and health outcome for our population, but it reduces pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have reduced mortality rates resulting from heart disease, cancer and stroke, and achieve better health outcomes at a lower cost than countries with systems that focus more heavily on a specialist level response.

Health services also play an important role in supporting people to regain functionality after illness and to remain healthy and independent for longer. Even where returning to full health is not possible, access to responsive needs-based pain management and palliative services (closer to home and families) can help to improve the quality of people's lives.

OVERARCHING OUTCOMES INDICATORS

Outcome: A reduction in acute medical admission rates

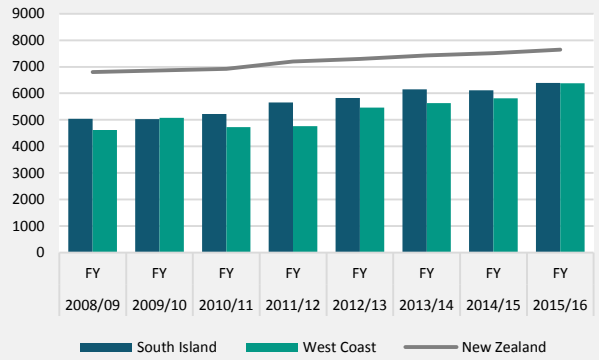
Like acute medical admission rates across the country our rates have continued to increase, but at 6,376 per 100,000 people, West Coast's rate is the third lowest in the country and well below the national rate (7,644).

This is a positive reflection of the system-wide focus taken on the West Coast to respond to people's needs and support them to better manage their long-Term conditions so they can avoid hospital admissions.

This includes the primary care led Long-term Conditions Management (LTCM) Programme which supports people to better manage their health and helps to prevent them from becoming acutely unwell. Over 3,700 people were enrolled in the Programme in 2015/16.

Data source: National Minimum Data Set.

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



Outcome: More people living in their own homes

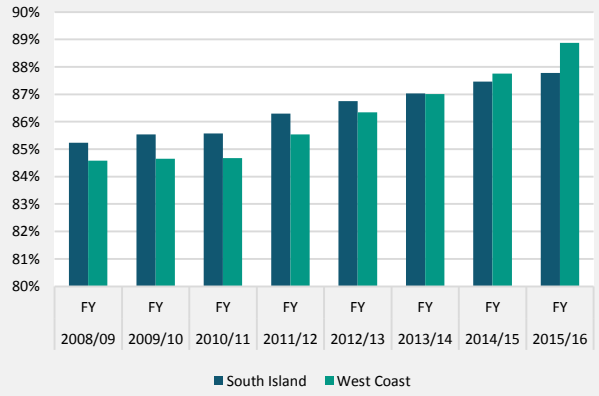
The percentage of the West Coast population (aged 75+) living in their own homes is now sitting at 88%.

Our rates are slightly higher than the rest of the South Island and consistent with our strategy of supporting people to stay safe and well in their own homes.

Our Complex Clinical Care Network (CCCN) supports older people on the West Coast to age-in-place with a multi-disciplinary team providing restorative home-based support, district nursing and respite services.

Data source: SIAPO Client Claims Payment System.

Measure: Percentage of the population (75+) living in their own home



IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

Impact: People's conditions are diagnosed earlier

Diagnostics are an important part of the healthcare system and timely access to diagnostics, by improving clinical decision-making, enables early and appropriate intervention and helps to improve the quality of care and outcomes for our population.

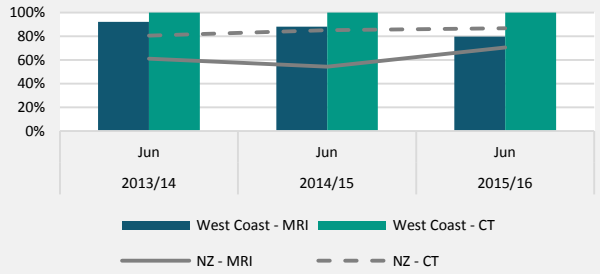
MRIs are delivered on behalf on the West Coast DHB by the Canterbury DHB who had been experiencing capacity issues over the past year.

This is getting back on track with the MRI scanner at the new Burwood Hospital now operational and a second MRI scanner being installed at Christchurch Hospital. This additional capacity will help to lift performance.

Data source: DHB Patient Management System.

Measure: Percentage of people waiting less than six weeks for CT/MRI scans

	2014/15	2015/16 Target	2015/16 Result
CT	100%	95%	100%
MRI	88%	85%	80%



Impact: Fewer avoidable hospital admissions

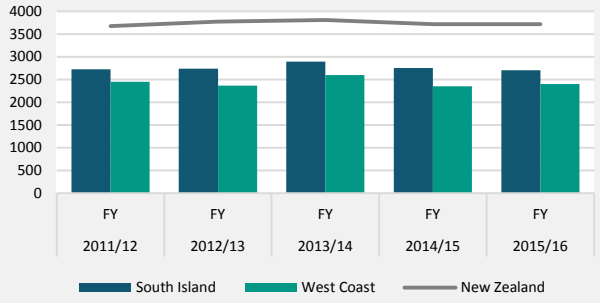
For the 2015/16 year, West Coast's avoidable admission rate was 2,401 per 100,000. This remains well below the national rate (3,717) and is consistent to previous years.

A wide range of local initiatives contribute to preventing unnecessary hospital admissions. These include our primary care-led Long-Term Conditions Management (LTCM) Programme, local HealthPathways and our community-based Complex Clinical Care Network all of which enable us to support people to better manage their health and wellbeing and avoid unnecessary hospital admission.

Data source: Ministry of Health.[7]

Measure: Ratio of actual vs. expected avoidable hospital admissions for those aged under 75

2013/14	2014/15	2015/16 Target	2015/16 Result
2,595	2,349	-	2,401



Impact: Fewer people admitted to hospital after falls

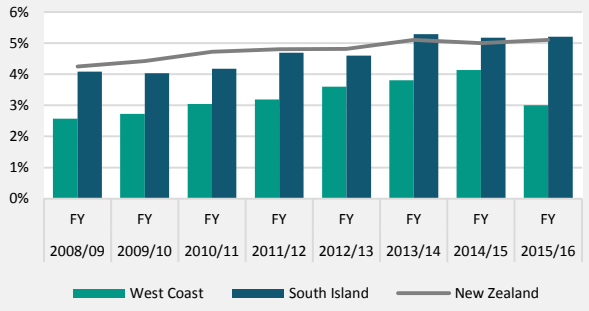
At 3%, the percentage of the population (75+) admitted to hospital as a result of a fall is lower than the previous year (4.1%) and well below national rates (5.1%).

We have a Falls Prevention Strategy in place in our hospitals, promoting clinically-led falls prevention and the use of care plans and strategies for patients at risk of falling.

Data source: National Minimum Data Set.[8]

Measure: Percentage of the population (75+) admitted to hospital as a result of a fall

2013/14	2014/15	2015/16 Target	2015/16 Result
3.8%	4.1%	<4.9%	3%



[7] *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. It is defined as a rate per 100,000 people and the target is set to maintain performance below national rates, reflecting less people presenting to hospital. At the time of preparing the 2015/16 Plan the Ministry was reviewing the definition for this measure and no targets were set. The definition was confirmed in October 2015 and the prior year's baselines and results were provided by the Ministry.*

[8] *The baseline results for this measure differ to those previously published due to an update of Census population numbers and national ICD codes. These updates have had a noticeable impact on the results – although trends remain similar. The target set for 2015/16 (7.8%) was out of line with the updated trend and was reset for the 2016/17 Annual Plan to maintain performance below the national average.*

Objective 3: People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

For people who need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning system – one that matches capacity to demand by making sure people get the right service, in the right place and at the right time.

This goal also reflects the importance of the quality of treatment we provide. Unnecessary waits, ineffective treatment or adverse events can cause harm and result in longer hospital stays, readmissions and complications that have a negative impact on the health of our population. Ineffective treatment and long waits, as well as wasting resources and adding unnecessary cost, also negatively impact on people's experience of care and their confidence in our health system.

OVERARCHING OUTCOMES INDICATORS

Outcome: A reduction in acute readmissions

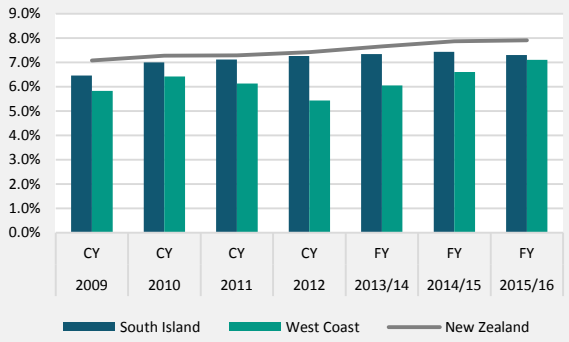
Small population numbers have a disproportionate effect on the results between years for the West Coast. The difference in the actual number of readmissions between 2014/15 and 2015/2016 is just 3 people.

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

We have continued to take a restorative approach when delivering home-based support services through our Complex Clinical Care Network and supporting people back into their own homes after discharge from hospital.

Data source: National Minimum Data Set.[9]

Measure: Rate of acute readmissions to hospital within 28 days of discharge



Outcome: A reduction in avoidable mortality

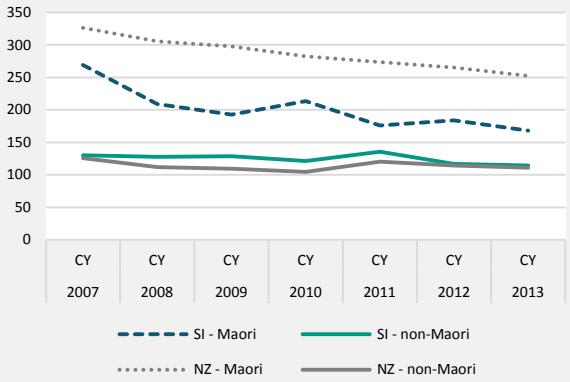
There has been a slight decrease in mortality rates across the South Island, for all ethnicities, and the overall trend continues to be positive with Maori rates consistently below national rates.

Our primary care-led Long-Term Conditions Management Program, reduced wait times and increased access to elective surgery are making a difference by ensuring effective diagnosis and increasing access to timely treatment.

Fewer adverse events occurring whilst in our hospitals, and the restorative focus through our Complex Clinical Care Network are also all factors which are positively influencing these results.

Data source: National Mortality Collection.[10]

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



[9] *This measure is a national performance indicator (OS8).*

[10] *Mortality data is sourced nationally and is released three years in arrears, the data presented was released in 2013 and results are provisional.*

IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

Impact: People have shorter waits for urgent care

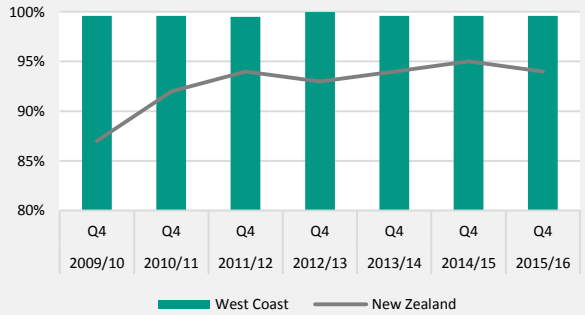
The West Coast has continued to be the leading performer nationally against the Shorter Stays in ED health target, with 99.6% of people presenting in our ED being admitted, transferred or discharged within six hours in the last quarter and 99.5% across the whole year.

A number of community-based urgent care options support our hospital ED including: free after-hours care for under thirteen year olds, telephone triage and extended access to general practice after hours.

Strong performance results also reflect the team work within ED and across the wider hospital to support the flow of patients and enable the ED team to respond well within target timeframes.

Data source: DHB Patient Management Systems.[11]

Measure: Percentage of people presenting in ED admitted, discharged, transferred within six hours	2013/14	2014/15	2015/16 Target	2015/16 Result
	99.6%	99.6%	95%	99.6%



Impact: People have increased access to planned care

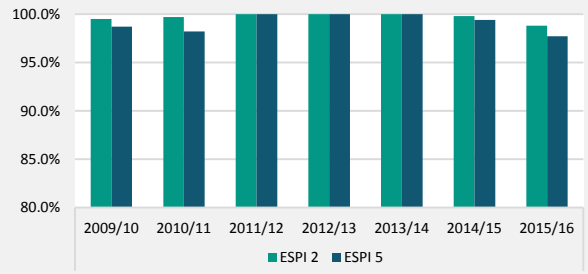
Of all West Coast residents referred for a specialist assessment 98.8% were seen within four months and 97.7% of those who were given a commitment waited no longer than four months for treatment.

These figures reflect increasing pressure in some service areas, particularly in orthopaedics and plastics, making it challenging to achieve the four month time frame for specialist assessment and treatment. Work is underway in these areas to support timeframes being met in a more consistent and sustainable manner.

Despite these pressures 1,942 elective surgeries were delivered for West Coast residents - more than ever before. These results reflect the continued commitment of the West Coast team to improve access to planned care for our communities.

Data source: Ministry of Health Quickplace Warehouse.[12]

Measure: Percentage of people receiving specialist assessment (ESPI 2) or treatment (ESPI 5) within 4 months		2014/15	2015/16 Target	2015/16 Result
	ESPI2	99.8%	100%	98.8%
	ESPI5	99.4%	100%	97.7%



Impact: People experience fewer adverse events

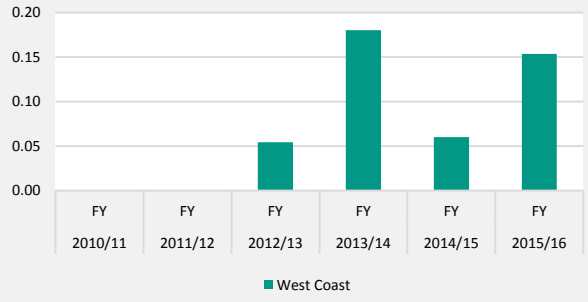
Once again, small numbers have a disproportionate effect on results for this measure. The overall rate of serious falls remains low with just 5 incidents in the past year compared to 2 incidents in 2014/15.

Our quality and nursing teams are focused on adopting the national falls assessment process and improving post-fall care. Falls assessments were provided to 88% of all inpatients (aged 75+) in the third quarter of this year, allowing mitigation strategies and care plans to be put in place for patients identified at risk.[13]

All serious incidents continue to be reviewed by the quality and clinical teams in each department to identify the cause and implement process improvements.

Data source: DHB Quality Reporting System.[14]

Measure: Rate of SAC level 1 & 2 falls in Hospital	2013/14	2014/15	2015/16 Target	2015/16 Result
	0.18	0.06	0.05	0.15



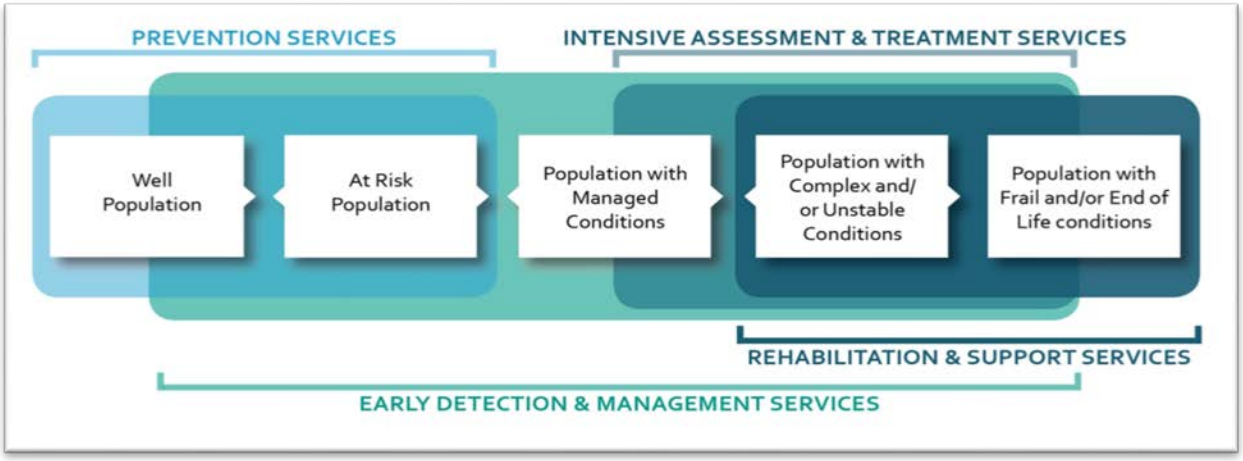
[11] *This measure is the national DHB health target (Shorter Stays in ED). The baselines differs slightly to those previously published (99.7% and 99.5%) having been updated to match the Q4 results in line with national reporting – rather than the full year as previous published.*

[12] *These two measures are part of the national Elective Services Patient Flow Indicators (ESPIs) set, established to track system performance. Standards are set nationally and in line with the ESPI reporting the results presented related to the final quarter of the year.*

[13] *The third quarter is the most recently published, as, the full year is not yet available. West Coast's result for Q1 was 88% and Q2 88%.*

[14] *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 represent those with both the highest consequence and likelihood. The rate is presented per 1,000 inpatient beds but small numbers still have a significant impact on these results — the 2015/16 result relates to 5 incidents.*

Statement of Service Performance Expectations



EVALUATING OUR PERFORMANCE

As both the major funder and provider of health and disability services on the West Coast, the decisions we make, and the way in which we deliver services, have a significant impact on people's health and wellbeing. Being responsible for the health and wellbeing of the population, we are strongly motivated to deliver the most effective and efficient services possible.

Over the longer-term we evaluate the effectiveness of our decisions and the quality of our service by tracking performance against the desired population health outcomes presented on page 6.

We also evaluate our service performance by providing an annual forecast of the services we plan to deliver and the standards we expect to meet. The following service statement presents our actual performance against our 2015/16 service forecast.[15]

Services are grouped into four services (or output) classes that are a logical fit with the continuum of care. These are: prevention services; early detection and management services; intensive assessment and treatment services; and rehabilitation and support services (illustrated above).

It would be overwhelming to measure every service we deliver. Instead we choose a mix of indicators for each service class that we believe are important to our community and stakeholders and will provide a fair representation of how well we are performing.

In doing so we measure more than just the volume of service delivered. The number of people who receive a service is often less important compared to whether enough people received the service, or whether the service was delivered at the right time. Our indicator mix includes four key aspects of performance: Volume (V), Timeliness (T), Coverage (C) and Quality (Q).

As well as comparing our performance against the standards set at the beginning of the year, we include prior years and national results to give wider context in terms of what we are trying to achieve and our performance over time.

SETTING STANDARDS

In setting performance standards, we considered the changing demographics of our population, areas of increasing demand and the assumption that resources and funding growth would be limited.

Targets reflect the objective of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions and maintaining service access while reducing waiting times and delays in treatment.

Our small population size means a very small number of people can have a disproportionate effect on our results. For this reason, some of the standards set may be particularly difficult for the West Coast DHB to meet. However, it is important that we strive to ensure our population has equitable access to services and we monitor these indicators in order to make appropriate funding decisions as we move forward.

[15] *The 2015/16 Annual Plan incorporating the DHB's statement of service performance is available on our website: www.westcoastdhb.health.nz.*

Children are getting a better start

More women are registering with a Lead Maternity Carer (LMC) within the first 12 weeks of pregnancy and 100% of new mothers attended DHB-funded parenting and pregnancy courses in 2015/16. The DHB has maintained its Baby Friendly Hospital accreditation and 246 babies were delivered on the Coast in the past year.

Despite the challenges with delivering vaccinations on the West Coast, almost 5,000 children under five received childhood vaccinations and 100% of all consenting children were immunised at eight months.

In 2015/16, West Coast's avoidable hospital admission rate for children 0-4 was 5,388 per 100,000. This is well below the national rate (6,789) and reflects fewer children being acutely admitted to West Coast hospitals.

The percentage of five-year-olds caries-free (no holes or fillings) has improved and we have reached the 56% target. An increase in the proportion of adolescents accessing free oral health services is also positive with rates increasing from 70% to 75% over the past year. A heightened focus on improving enrolment rates and capacity across our school and community dental services over the coming year should help to maintain continued momentum in this area.

People are healthier

Over 4,500 smokers received brief advice and support to quit in primary care and in our hospital facilities. Our staff have delivered brief advice to 97% of all hospitalised smokers in the final quarter of this year. This is a significant achievement. Our primary care results were lower, 79% against the national better help for smokers target in the final quarter, but we reached 82% of the enrolled population over the whole year. The results of our efforts in this area are beginning to show with smoking prevalence dropping from 25% to 22% between the 2006 and 2014 New Zealand Health Surveys and 80% of Year 10 students reported never having smoked in 2015.

The proportion of people accessing screening continues to increase with 75% of women having had a cervical screen and 76% having had a mammogram in the past year. In the last five years 91% of the eligible population had a cardiovascular risk assessment, 1% above the national target, and 91% of people with diabetes had an annual condition review. These services help people to identify issues early and avoid unnecessary complications that might lead to a hospital admission or negative health outcomes that might have been avoided.

The number of people seeking physical activity support has continued to rise with 543 people receiving green prescriptions in the past year. More than half of the participants (58%) reported being 'more active' 6-8 months later.

We are supporting more people to stay well in their own homes and communities

We have continued to work on the development of HealthPathways to ensure a consistent approach to care and equitable access for our population and 654 localised pathways are now in place between primary and secondary care. All but one general practice on the West Coast is providing after-hours telephone triage and 100% of children (under thirteen) now have access to free primary care after-hours.

Our investment in Brief Intervention Counselling Services mean more than 200 young people and 500 adults were able to access mental health support from their general practice over the past year.

Enrolments in our primary care-led Long Term Conditions Management Programme also continue to increase with 3,793 people enrolled in the programme at the end of 2015/16. The support of general practice services is core to managing the health of our population and high enrolments are an indication of good engagement with general practice.

More people are receiving timely specialist care.

We delivered 1,942 elective surgical discharges in the past year, 53 more than the target enabling more people to get on with their lives. More than 6,500 patients also attended a first specialist assessment in the past year - 98.8% of whom waited no more than 4 months for their appointment.

There were over 11,500 attendances at the Grey Hospital emergency department – 366 more than the previous year. However, we have continued to meet the waiting time health target ensuring 100% patients are admitted, discharged or transferred within six hours. The West Coast has been at the top of the national league table for this waiting time health target all year.

We delivered more than 15,000 outpatient appointments. An increasing number were delivered using telemedicine technology meaning less disruption for patients who do not have to travel as far for their appointment, or stay overnight in Canterbury. Did-not-attend rates for outpatient appointments continue to drop which is really positive. When patients do not attend appointments

it can negatively affect their recovery and is also costly in terms of wasted resource for the DHB.

Waiting times for diagnostics are on track with 100% of people receiving urgent colonoscopies within two weeks and 100% of people waiting no more than six weeks for their CT scans. Only 12 people waited longer than six weeks for their MRI scan with 80% of people being seen within the target time.

We are also ensuring that anyone waiting for chemotherapy or radiotherapy is starting their treatment within 4 weeks. This target has been consistently met for a number of years. We are working towards achieving the new national faster cancer treatment health target and 80% of people (referred with a high suspicion of cancer and a need to be seen within two weeks) received their first treatment within 62 days of being referred.

We are improving patient safety

Our commitment to Zero Harm and implementation of the Health Quality and Safety Commission's "Open for Better Care Campaign" resulting in 88% of inpatients over the age of 75 receiving a falls risk assessment in 2015/16 – 2% higher than the national average. Falls assessments enable care plans and mitigations strategies to be put in place to reduce the likelihood of people falling, and only five people experienced a serious fall causing harm in our hospitals this year.

We are supporting people's recovery and rehabilitation

At 3%, the percentage of the West Coast population (aged over 75) being admitted to hospital as a result of a fall continues to drop and is well below the national average (5.1%). After a number of recruitment challenges we have appointed a clinical falls lead and our Falls Prevention Programme is underway. Sixteen people accessed the service in the first two months - May and June of 2016.

Our Complex Clinical Care Network (CCCN) provides a range of home-based support and nursing care to support people to leave hospital sooner and avoid readmission. In the past year 786 people have been supported by long-term home and community services, 4,246 district nursing visits were provided and over 33,000 meals on wheels were delivered.

Despite increasing referrals for needs assessments, 93% of clients receiving long term home support services have received a comprehensive InterRAI assessment, to ensure they are getting the services they need.

Consistent with our strategy of supporting our older population to age-in-place, the number of older people living in their own homes continues to increase, and at 88% is slighter higher than the average for the South Island.

NOTES ON THE DATA:

Rather than repeating footnotes, the following symbols have been used in the performance tables:

E Some services are demand driven (such as: diagnostic tests and assessments, emergency, maternity, rehabilitation, dementia and palliative care services) and it is not appropriate to set targets, instead estimated volumes are provided to give context as to the use of resource across our system.

Δ Performance data provided by external parties can be affected by a delay in invoicing or reporting and previous results are subject to change due to incorporation of late data.

† Performance data for some programmes relates to the calendar year rather than financial year.

◇ National Health Targets are set for DHBs to achieve by the final quarter of the year. In line with national reporting the performance result relates to the fourth quarter of the year.

◆ The DHB has a Māori Health Action Plan. Where the 2015/16 performance indicators aligned they had been mixed into the statement of service performance to highlight areas of particular priority for Māori. The DHB has elected to show performance against the full set of Maori Health Action Plan indicators rather than the smaller subset initially proposed refer to page 26.

Performance Key

Rating	Criteria
Achieved	Standard reached
Partially Achieved	Standard not reached but performance improved or maintained
Not Achieved	Standard not reached and performance dropped

Prevention services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Preventative health services promote and protect the health of the population and address individual behaviours by targeting changes to physical and social environments that support people to make healthier choices. By supporting people to make healthier choices and to modify their lifestyles we can reduce the risk factors that contribute to long-term conditions and prevent or minimise the impact of these conditions.

At-risk and high-need population groups are more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore our foremost opportunity to target improvements in the health of these populations and to reduce inequalities in health status and health outcomes. Because prevention services are often designed to disseminate consistent messages to large numbers of people and population groups they can also be very cost-effective.

SERVICE PERFORMANCE (2015/16)

Health Promotion and Education Services							
These services inform people about risks and support them to make healthy choices. Success begins with awareness and engagement followed by positive behaviour changes.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Lactation support and specialist advice consultations provided in community settings	V	117	172	>100	214	-	A
Babies exclusive/fully breastfed at LMC discharge	Q [16]	80%	75%	>75%	n.a	n.a	-
Priority schools supported by the Health Promoting Schools Framework	C [17]	100%	100%	>70%	100%	-	A
Nutrition and activity courses provided in the community	V [18]	7	9	>5	4	-	N
People referred to Green Prescriptions for additional physical activity support	V [19]	474	478	500	543	-	A
Green Prescriptions participants more active 6-8 months after referral	Q [20]	80%	86%	>50%	58%	75%	A
Smokers enrolled with a PHO receiving advice/help to quit	C ◇ [21]	62%	90%	90%	79%	88%	N
Smokers identified in hospital receiving advice/help to quit	C ◇	95%	98%	95%	97%	96%	A
Enrolments in Aukati Kaipaipa smoking cessation programmes	V [22]	129	175	>100	67	-	N
Women smokefree at two weeks postnatal	Q [23]	88%	81%	95%	76%	-	N

[16] *This measure is part of the national Well Child Quality Framework and standards are set nationally – results for the 2015/16 year had not been released nationally at the time of printing.*

[17] *The Health Promoting Schools Framework is a DHB sponsored programme that supports schools to addresses health issues through the promotion of 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.*

[18] *Although six courses were commenced, low attendance rates meant two were cancelled, the DHB is revising course content for 2016/17.*

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

[20] *The national average result is not available therefore the result is across Canterbury, South Canterbury and West Coast. While the uptake of the green prescriptions is positive, further work is need to lift activity rates in the coming year and this remains a priority for 2016/17.*

[21] *This is a national health target measure (Better Help for Smokers to Quit). In 2014-15 the definition changed from 'people offered advice and support within the last 12 months' to 'within the last 15 months' (being the 15 months to June). The DHB was disappointed with the drop in performance in the final quarter to 79% - previous quarters had been higher refer to the health target breakdown on page 25.*

[22] *The DHB has gain national support for a local smoking cessation proposal and we expect to lift rates back up in the coming year.*

[23] *This measure is part of the national Well Child Quality Framework and standards are set nationally. The 2015-16 results reflect the 6 months to December 2015, as the full year was not available at the time of printing. Rates are not as high as we would like and reducing smoking prevalence amongst pregnant women is a priority in the DHB Maori Health Plan for 2016/17.*

Population-Based Screening Services							
These services help to identify people at risk of illness and pick up conditions earlier. Success is indicated by high engagement and coverage rates.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Four-year-olds receiving a B4 School Check (B4SC)	C [24]	90%	92%	90%	74%	92%	N
Year 9 students (in decile 1-3 schools) receiving a HEEADSSS assessment	C †[25]	55%	46%	95%	68%	-	P
Women (25-69) having a cervical smear in the last 3 years	C [26]	79%	74%	80%	75%	77%	P
Women (50-69) having a mammography in the last 2 years	C [26]	80%	75%	>70%	76%	71%	A

Immunisation Services							
These services reduce the transmission and impact of preventable diseases. Success is indicated by high engagement and coverage rates.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Newborns enrolled on the Nat. Immunisation Register at birth	C	100%	100%	>95%	100%	-	A
Children fully immunised at eight months of age	C ◇[27]	81%	85%	95%	78%	93%	N
Eight-month-olds 'reached' by immunisation services	Q [28]	96%	98%	95%	100%	97%	A
Year 8 girls completing their HPV vaccinations (Dose 3)	C †[29]	54%	53%	65%	43%	65%	N
Older people (65+) receiving a free influenza (flu) vaccination	C †	63%	64%	75%	61%	67%	N

[24] The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development. Performance has dropped against previous years due to a number of challenges including a significant number of families moving away from the Coast over the past year (so checks cannot be completed) and capacity delays in completing one element of the checks which means they cannot be counted. We expect with reforecast population numbers for 2017/18, that the results will improve again in the coming year.

[25] A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety. The DHB has been working closely with schools to lift the check rates and has implemented a new consents process which is beginning to show improved results.

[26] The cervical and breast cancer screening programmes are national programmes where age bands and standards are set nationally. The 2013/14 result for breast screening is against the previous age bands (45-69) and is not directly comparable.

[27] The West Coast DHB has a large community within its population who decline immunisations and this makes delivering all of the national immunisation targets extremely challenging. The opt-off and decline rate for eight month olds was 21.7% in the final quarter.

[28] '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. This measure is included to reflect how well the DHB and general practice teams are doing at contacting parents and providing professional advice - irrespective of the final choices made by parents who may choose to decline immunisations or opt off the National Immunisation Register.

[29] The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer. The Programme currently consists of three vaccinations and is free to young women under 20 years of age. The results measure Year 8 girls (being born in 2002) receiving Dose 3 by the end of 2013. The DHB is working with schools to lift these numbers and encourage young girls to engage in the HPV programme. However like all the immunisation targets, strong anti-immunisation views make this challenging. We also have higher than usual number of young women counted in Census but not at school on the Coast or moving from the Coast during the year, making this a challenging target. It remains a focus for 2015/16.

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 can 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 where they have a long-term condition, can help to reduce or avoid negative complications, acute illness or crises, they help reduce the need for a hospital appointment or hospital admission. These services therefore have a major impact on people's health and wellbeing but also on the capacity of the health system, freeing up hospital and specialist services to allow for more complex and planned interventions.

SERVICE PERFORMANCE (2015/16)

Primary Care Services							
These services are offered in community settings by general practice and allied health professionals to improve, maintain, or restore people's health. Engagement rates and uptake of services is indicative of the accessibility and responsiveness of primary care services.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
DHB population enrolled with a Primary Health Organisation	C [30]	92%	91%	95%	89%	-	N
Number of HealthPathways in place across the health system	V [31]	434	614	650	654	-	A
Avoidable hospital admission rate for children (0-4)	Q [32]	5,278	4,423	-	5,388	6,789	A
Young people (0-19) accessing Brief Intervention Counselling	V Δ [33]	65	126	>80	219	-	A
Adults (20+) accessing Brief Intervention Counselling	V Δ [33]	374	413	>300	548	-	A

Oral Health Services							
These services help people maintain healthy teeth and gums. High enrolment and timely examination and treatment indicates a well-functioning and efficient service.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Children (0-4) enrolled in DHB-funded oral health services	C † [34]	75%	100%	90%	87%	-	N
Enrolled children (0-12) examined according to planned recall	T †	78%	89%	90%	78%	-	N
Adolescents (13-17) accessing DHB-funded oral health services	C †	72%	70%	85%	75%	66%	P

[30] *Results have been affected by a shift in the population (with people moving from the Coast). The measure compares those enrolled with the estimated 2015/16 population. If we took the most recent population update for 2016/17, enrolments would be at 91%.*

[31] *The HealthPathways website helps ensure a consistent approach to care and equitable access to services by providing general practice with online access to clinically designed pathways that guide patient care and provide advice on treatment.*

[32] *This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. Some hospital admissions are seen as avoidable through early intervention and treatment and this measure is therefore seen as an indication of the accessibility and effectiveness of primary care. The aim is to maintain performance below the national rate, which reflects less people presenting to hospital. At the time of preparing the 2015/16 Plan the Ministry was working to resolve a definition issue with this measure and target setting was postponed. The results presented are based off the definition set in October 2015 with the baselines having been provided by the Ministry. Because of the delays no targets were set for this measure in 2015/16. The DHB has recognised its performance as positive due to being maintained below national rates.*

[33] *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. In the past year a joint triage process between primary care and specialist child and adolescent services has been introduced and the primary-care led Long-Term Conditions Management Programme has been expanded to incorporate people with mental health issues. Both these factors have helped contributed to an increase in referrals to the brief intervention service.*

[34] *In the coming year the DHB is reviewing its oral health service enrolment processes and linking the School and Community Dental Service in with the Immunisation and Well Child teams to encourage families to connect with services and lift enrolment rates. The service is carrying a long-term vacancy and has had a number of staff on long-service leave over the past year which has meant examination rates have dropped behind – addressing arrears will also be a key focus in 2016/17.*

Long-Term Conditions Management Services (LTCM)

These services are targeted at people with high health needs to support and improve the management of their conditions. Success is demonstrated through the uptake of monitoring and management services which can reduce complications and lead to negative health outcomes and hospital admission.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People identified with a long-term condition enrolled in the primary care LTCM Programme	V	2,767	3,666	>2,000	3,793	-	A
People with diagnosed diabetes having an annual LTMC review	C	99%	96%	>90%	91%	-	A
People with diabetes having satisfactory or better diabetes management (Hba1c ≤ 64mmol/mol) at their annual review	Q [35]	78%	69%	80%	63%	-	N
Eligible population having a CVD Risk Assessment in the last 5 years	C ◇	77%	91%	90%	91%	91%	A

Pharmacy and Referred Services

These are services which health professionals may use to help diagnose or monitor a health condition. While largely demand driven; access to these services improves clinical decision-making and reduces unnecessary delays in treatment.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Subsidised pharmaceutical items dispensed in the community	V Δ [36]	445k	443K	E.<600K	455K	-	A
Community requested radiological tests delivered by Grey Hospital	V [37]	5,590	5,289	E.>5,000	5,504	-	A
People receiving urgent diagnostic colonoscopy within 2 weeks	T ◇ [38]	33%	83%	75%	100%	55%	A
People receiving CT scans within 6 weeks	T ◇	100%	100%	>95%	100%	87%	A
People receiving MRI scans within 6 weeks	T ◇	92%	88%	85%	80%	70%	N

[35] *An annual review includes an HbA1c test of patient's blood glucose levels to assessing the management of people's diabetes condition - HbA1c ≤64mmol/mol reflects an acceptable blood glucose level. Performance is a little lower than in previous years and the DHB and PHO remain committed to the delivery of the LTCM programme to better support people to manage their complex conditions including diabetes.*

[36] *This measure may include some non-West Coast residents who had prescriptions filled while on the Coast.*

[37] *The baselines result for 2014/15 has been corrected (from 5,935) for consistency with the 2013/14 definition.*

[38] *These diagnostic measures are national performance measures (PP29). Standards are set nationally and results are for the final month of the year (June) in alignment with national results published by the Ministry of Health. Small population numbers can disproportionately affect the results for the diagnostic measures – the total number of urgent colonoscopies delivered on time was five out of five and the total number people seen outside of the target time for MRI scans in 2015/16 was 12 people. Canterbury delivers the MRI scans for the West Coast and Canterbury have been experiencing capacity issues with their rebuild and repair programme underway, a new MRI scanner will be coming online this year which will enhance capacity and improve waiting times.*

Intensive assessment and treatment services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enables people to establish more stable lives, and results in improved public confidence in the health system.

As an owner of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Improved systems and processes will improve patient safety, reduce the number of events causing injury or harm and improve overall health outcomes.

SERVICE PERFORMANCE (2015/16)

Quality & Patient Safety							
These quality and patient safety measures apply across all hospital services. High compliance levels indicate robust quality processes and strong clinical engagement.[39]	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Rate of compliance with good hand hygiene practice	Q ◇[40]	77%	83%	80%	78%	81%	N
Hip and knee replacement patients receiving cefazolin >2g	Q ◇[41]	89%	100%	95%	95%	96%	A
Hip and knee replacement patients receiving appropriate skin preparation	Q ◇	100%	100%	100%	100%	100%	A
Proportion of time all three parts of the Surgical Safety Checklist are used	Q ◇[42]	96%	94%	90%	-	-	-
Inpatients (aged 75+) receiving a falls assessment	Q ◇[43]	89%	88%	90%	88%	86%	P

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 utilisation is monitored to ensure capacity and responsiveness to needs.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Women registered with an LMC by 12 weeks of pregnancy	C	62%	56%	80%	60%	59%	P
Proportion of new mothers attending DHB-funded parenting and pregnancy courses	C	N/A	69%	>30%	100%	-	A
Maternity deliveries in West Coast DHB facilities	V	279	256	E. 300	246	-	A
Baby friendly hospital accreditation of DHB facilities	Q[44]	Yes	Yes	Yes	Yes	-	A

[39] *These quality measures are national safety markers with definitions and standards set nationally. Baselines have been updated to the final quarter of each year some of which were not available at the time of printing. The 2015/16 results are the most recent available being Q3 (January-March 2016).*

[40] *This measure is based on ward audits of the Medical and Surgical Wards conducted according to Hand Hygiene NZ standards.*

[41] *Cefazolin >2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.*

[42] *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. This measure was retired from the national programme at the beginning of 2015/16.*

[43] *While there is no single solution to reducing falls, an essential first step is to assess an individual's risk of falling, and acting accordingly.*

[44] *The Baby Friendly Initiative is a worldwide programme lead by 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 the standard.*

Acute/Urgent Services

These are medical or surgical services delivered in response to illnesses that have an abrupt onset or progress rapidly. While largely demand driven, earlier intervention and shorter wait times are indicative of an effective system.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Children (0-13) with access to free primary care after hours	C	new	new	100%	100%	-	A
General practices providing telephone triage after hours	C [45]	100%	88%	100%	88%	-	P
Attendances at the Grey Base Hospital Emergency Department	V [46]	11,043	11,376	E.<13,000	11,742	-	A
People (triage level 1-3) presenting in Emergency who are seen within clinical guidelines	Q [47]	87%	85%	>85%	80%	-	N
People (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T ◇ [48]	New	50%	85%	80%	74%	P
People waiting less than 4 weeks to start radiotherapy or chemotherapy	T ◇ [49]	100%	100%	100%	100%	100%	A
Acute inpatient average length of stay (standardised)	Q	2.45	2.35	≤2.45	2.40	2.64	A

Elective/Arranged Services

These are services for people who do not need immediate hospital treatment, where treatment is 'booked' or 'arranged'. Increased assessed and shorter wait times are seen as indicative of an effective system.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
First specialist assessments provided (medical and surgical)	V [50]	6,864	6,663	E.>6,000	6,591	-	A
First specialist assessments that were non-contact (virtual)	Q [51]	4.2%	5.5%	>5%	12.5%	-	A
Elective surgical discharges (surgeries provided)	V [52]	1,695	2,053	1,889	1,942	-	A
Elective inpatient average length of stay (standardised)	Q	1.59	1.63	≤1.59	1.55	1.67	A
Outpatient appointments/consultations provided	V [53]	17,706	16,903	E. >13,000	15,257	-	A
Outpatient appointments/consultations provided by telemedicine	Q	2.2%	2.2%	>1.5%	2.6%	-	A
Outpatient 'Did not Attend' rates	Q [54]	7.9%	6.9%	6%	6.0%	-	A

[45] *The difference between 100% and the 88% result is one practice, who continues to redirect callers to Healthline after hours.*

[46] *This measure uses the definitions for the national health target (Shorter Stays in ED) and reflects attendances at Grey Hospital ED.*

[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 the national health target (Faster Cancer Treatment) which was introduced in Q2 of 2014/15 and presents a rolling six month result to June. The 80% performance result for quarter four reflects just two patients missing target.*

[49] *This measure is a national performance measure (PP30) and refers to all people 'ready for treatment'. It excludes Category D patients, whose treatment is scheduled with other treatments or as part of a trial.*

[50] *This 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. The measure is aligned to the national elective services reporting definitions which are DHB of domicile - covering all FSAs provided for West Coast residents no matter where they are delivered.*

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

[52] *This measure is the national health target (Improved Access to Elective Surgery). The measure was redefined in 2015/16 to include inpatient surgical discharges, regardless of whether the discharge is from a surgical or non-surgical speciality and both 'elective' and 'arranged' admissions. Baselines from 2014/15 have been aligned to the new definition.*

[53] *This measure relates to medical and surgical specialist outpatient appointments and excludes mental health or AT&R services.*

[54] *This measure is calculated as the proportion of all outpatient appointments where the patient was expected to attend on the day but did not. When patients fail to turn up to scheduled appointments it can negatively affect their recovery and long-term outcomes and it is also costly in terms of wasted resources for the DHB.*

Specialist Mental Health Services							
These are services for those most severely affected by mental illness or addictions. Improved access and shorter wait times are indicative of the systems positive response to demand.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Young people (0-19) accessing specialist mental health services	C Δ[55]	6.1%	6.1%	>3.8%	5.5%	3.7%	A
Adults (20-64) accessing specialist mental health services	C Δ	5.4%	5.0%	>3.8%	5.2%	3.9%	A
People referred for non-urgent mental health and Alcohol and Other Drug (AOD) services, seen within 3 weeks	T [56]	76%	77%	80%	81%	80%	A
People referred for non-urgent mental health and AOD services, seen within 8 weeks	T	93%	93%	95%	94%	94%	P

Assessment, Treatment and Rehabilitation Services (AT&R)							
These are services that restore people's functional ability and enable them to live as independently as possible. Success is measured through an increase in the rate of people discharged home, rather than into residential care or into hospital settings.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Consultations provided by outpatient and domiciliary AT&R services	V	2,060	3,194	E.>1,700	2,716	-	A
Admissions into inpatient AT&R services	V [57]	131	124	E.>150	91	-	N
AT&R inpatients discharged to their own home rather than into aged residential care	Q Δ[58]	89%	83%	90%	82%	-	N

[55] *This measure is based on the previous national performance measure (PP6) and standards are set nationally based on the expectation that 3% of the population will need access to higher-level mental health support. Results reflect specialist services reporting through to the national PRIMHD database. The drop off in rates is positive as the teams shift the focus to earlier intervention, reflected in the increased brief intervention service delivered volumes.*

[56] *This measure is a national performance measure (PP8) and targets are set nationally. Results are three months in arrears and reflect specialist services (DHB and NGO) reporting through to the national PRIMHD database. The West Coast has been having some issues with the reporting system and these results reflect longer waiting times than results collected internally over the most recent quarter.*

[57] *An increasing focus on restorative care delivered in people's own homes (via the DHB's Complex Clinical Care Network) is resulting in fewer people needing to be admitted into our hospitals in order to access Assessment Treatment and Rehabilitation (AT&R) services.*

[58] *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) can reflect the quality of services in terms of assisting people to regain their functional independence. However, the DHB is reviewing this measure - as more of the less complex patients are accessing AT&R services in their own homes those people in AT&R beds are likely to be more complex and are more likely to end up in residential care. We are also reflecting small numbers, the drop between 2014/15 and 2015/16 is 4 people.*

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 and can reduce pain and suffering.

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 people to go home earlier and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

SERVICE PERFORMANCE 2015/16

Rehabilitation Services							
These services restore or maximise people's health or functional ability following a health-related event such as a heart attack or stroke. Success is measured through increased referral to services following an acute event.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	C [59]	55%	41%	80%	31%	-	N
People supported by the FIRST service	V [60]	new	new	25	n.a	-	N
People (65+) accessing the community-based falls/fracture liaison service	V [60]	new	new	25	16	-	N

Home and Community-Based Support Services							
These are services that help restore functional independence and support people to continue living in their own home. Largely demand driven, clinical assessment ensures appropriate and equitable access to services.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People supported by long-term home and community support services	V Δ	751	792	E. >740	786	-	A
Proportion of people (65+) receiving long-term home and community support services, who have had a clinical assessment using InterRAI	Q Δ [61]	94%	93%	95%	93%	-	P
Community-based district nursing visits provided	V Δ [62]	4,364	4,171	E. >4,000	4,246	-	A
Meals on Wheels provided	V Δ	33,082	37,306	E. >35k	33,561	-	A

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. Success is measured by increased access and effective use of capacity.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People supported by aged care respite services	V	64	56	E. 70	61	-	A
Mental health planned and crisis respite bed days used	C Δ	379	457	E. 500	365	-	A

[59] *Small patient numbers have a disproportionate effect on results – this reflects 14 people. The DHB will continue to work with the South Island Stroke Network to improve the journey for patients with stroke and to implement the NZ Stroke Guidelines on the West Coast.*

[60] *These measures were set with anticipation that services would be in place and operational this year. Unfortunately the DHB continued to experience recruitment challenges and implementation of FIRST and the Falls/Fracture service have all been delayed. A FIRST steering group is now in place and the service is expected to get underway in 2016/17. A clinical falls lead was appointed in April 2016 and 16 people have accessed the Falls Prevention service in the first two months (May and June of 2016). The Fracture service role is still vacant.*

[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.*

[62] *This measure refers to long-term clients only.*

Residential Care Services							
These services meet the needs of people assessed as requiring long-term residential care. With an ageing population, overall demand is expected to increase, but a reduction in demand for lower-level rest home care is seen as indicative of more people being successfully supported to remain in their own homes.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Proportion of people entering aged residential care (ARC) having had an clinical assessment using InterRAI	Q Δ[63]	97%	97%	>95%	90%	-	N
ARC residents receiving vitamin D supplements	C [64]	59%	59%	75%	70%	-	P
Subsidised ARC rest home beds provided (days)	V Δ[65]	43,150	40,488	E. <50k	35,363	-	A
Subsidised ARC hospital beds provided (days)	V Δ[65]	39,099	37,537	E. <40k	37,843	-	A
Subsidised ARC dementia beds provided (days)	V Δ[65]	3,434	5,399	E. >4,000	5,439	-	A
Subsidised ARC psycho-geriatric beds provided (days)	V Δ[65]	2,296	2,167	E. >2,000	3,314	-	A

[63] *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. We have had a drop-off in these rates with turnover of staff and are working with the Ministry to increase access to national training programme for nurses on the West Coast to lift these rates.*

[64] *The data collection methodology for this programme has been reviewed and there are a number of caveats which suggest this measure may undercount Vitamin D prescribing in ARC. The DHB has elected not to continue reporting this measure until these can be verified.*

[65] *Baselines for the ARC bed day baseline volumes have been revised from those previously published, to reflect improved data recording and calculations around start and end dates of stay. Trends are still consistent 2014/15 bed-days were: rest home 42,324, hospital 40,759, dementia 6,607, psycho-geriatric 2,734.*

National Health Target Performance

2015/16 was a positive year in terms of delivery against the national health targets. We improved or maintained performance on all but two of the targets. The table below shows the quarterly results across the year.

National Health Targets							
Success is measured by achievement of the target but also by improved performance and comparison to other DHBs.	2015/16 Target	Q1	Q2	Q3	Q4	National Average	Rating
Children fully immunised at eight months of age	95%	88%	81%	89%	78%	93%	N
Smokers enrolled with a PHO receiving advice and help to quit	90%	84%	85%	82%	79%	88%	N
Smokers identified in hospital receiving advice and help to quit	95%	91%	96%	94%	97%	96%	A
Eligible population having a CVD risk assessment in the last 5 years	90%	91%	91%	90%	91%	91%	A
Percentage of people presenting in ED admitted, discharged or transferred within six hours	95%	100%	100%	99%	100%	94%	A
Elective surgical discharges delivered (surgeries provided)	1,889	480	978	1,442	1,942	-	A
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral	85%	50%	71%	75%	80%	74%	P

Small population numbers and a large number of parents opting out or declining immunisations makes this health target challenging for the West Coast. The focus for our teams continues to be on reaching all parents and offering immunisation and 100% of the consenting population were immunised in the final quarter of this year.

We achieved the Better Help for Smokers to Quit - Hospitals health target, with 97% of hospitalised smokers having received help and advice to quit in the final quarter. Progress against the Better Help for Smokers to Quit – Primary Care health target has not been as positive in the final quarter of the year and we have not made the target this year. Best-practice initiatives continue to be supported to improve performance including dashboards, education, and active clinical leadership.

Performance against the More Hearts and Diabetes Checks target has been really positive this year, with performance at or above target in every quarter this year. This will no longer be a national health target in 2016/17 (being replaced with the Raising Healthy Kids target) but will still be tracked as part of our service performance reporting and will remain a focus in our Long-Term Conditions Management Programme.

Delivery against the national Shorter Stays in ED and Elective Surgery targets have also been particularly impressive this year. The ED team continues to work closely with community organisations, the discharge planning group and acute admitting wards to ensure the smooth flow of patients. Frail elderly pathways are being established to better support this high-need group of patients and the transalpine approach with Canterbury has helped the West Coast exceed the electives health target by 53 surgeries.

The West Coast sits at the top of the national performance table for the Shorter Stays in ED health target and we have consistently achieved this target in every quarter of the year.

Performance against the new Faster Cancer Treatment target is steadily progressing. Small numbers are a challenge with this target and the 80% performance result for quarter four reflects just two patients missing target.

Maori Health Plan Performance

Setting alongside its Annual Plan and Statement of Intent, the DHB also has a Maori Health Action Plan which sets out planned activity and standards against a set of national indicators, specifically established to support improvements in health outcomes for Maori. The 2015/16 Maori Health Action Plan is available on our website and performance against the indicators in the Action Plan are presented below.

Maori Health Action Plan Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Maori and non-Maori.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National	Rating
Māori population enrolled with a PHO	C	92%	90%	95%	89%	-	N
Māori women smokefree at two weeks postnatal	Q [66]	90%	27%	95%	n.a	n.a	-
Māori babies exclusive/fully breastfed at LMC discharge	Q [66]	42%	41%	75%	n.a	n.a	-
Māori babies exclusive/fully breastfed at 3 months	Q [66]	n.a	57%	60%	n.a	43%	-
Māori babies receiving breast milk at 6 months	Q [66]	n.a	57%	65%	n.a	53%	-
Māori babies fully immunised at eight-month-olds	C	94%	80%	95%	82%	90%	P
Rate of avoidable hospital admissions for Māori (0-4 years)	Q [67]	8,571	5,581	-	6,136	7,631	A
Māori children (0-4) enrolled in DHB dental services	C † [68]	66%	88%	90%	75%	-	N
Eligible Māori men (35-44) who have had their CVD risk assessed within the past five years	C [69]	-	new	90%	65%	68%	P
Māori women (25-69) who have had a cervical smear in the last three years	C [70]	73%	62%	80%	68%	66%	P
Māori women (50-69) who have had a mammography in the last two years	C [70]	77%	76%	70%	70%	65%	A
Older Māori (65+) having had a seasonal influenza vaccination	C † [71]	72%	69%	75%	64%	-	N
Rate of avoidable hospital admissions for Māori (45-64 years)	Q [73]	4,471	2,772	-	4,440	6,821	A
High-risk Māori receiving an angiogram <3 days of admission	Q◇ [72]	new	0%	70%	100%	-	A
Māori presenting with Acute Coronary Syndrome undergoing angiography with completion of registry data within 30 days	Q◇	new	100%	95%	100%	-	A
Rate of rheumatic fever in the South Island (per 100,000)	Q	0.4	0.4	<0.2	0.4	2.1	P
Rate of compulsory treatment orders for Māori (per 100,000)	Q [73]	87	54	-	132	294	-
Regular activity reporting to the Healthy West Coast Alliance	Q	yes	yes	yes	yes	-	A
Māori Outpatient 'Did not Attend' rates	Q [74]	16.2%	14.8%	6%	13.6%	-	P

[66] *These measures are part of the national Well Child performance framework and standards are set nationally. The 2015/16 results were not available by ethnicity at the time of printing.*

[67] *At the time of preparing the 2015/16 Plan the Ministry was working to resolve a definition issue with this measure and target setting was postponed. The definition was set in October 2015 and the Ministry provided previous years baselines as presented. No targets were set for this measure in 2015/16 and the DHB has recognised its performance as below national rates.*

[68] *The DHB is reviewing its oral health enrolment processes and linking the School and Community Dental Service in with the Immunisation and Well Child teams to encourage families to connect with services and lift enrolment rates.*

[69] *More work is needed to lift these rates and oral health enrolments is a priority area in the DHB's Maori Health Plan for 2016/17.*

[70] *The cervical and breast cancer screening programmes are national programmes and age bands and standards are set nationally. The 2013/14 result for breast screening is updated for the full year but against the previous age bands (45-69) and is not directly comparable.*

[71] *As highlighted earlier in the document, immunisation targets are challenge for the West Coast but continue to be a focus for 2015/16.*

[72] *These are national measures but reflect very small numbers: in 2015/16 there was one Maori patient who received an angiogram.*

[73] *These results are the latest available nationally to the end of Q3 - March 2016. This is a national measure that for the Coast reflects very small (and easily fluctuating) numbers - the 2015/16 result is five people.*

[74] *Maori DNA rates are significantly higher than the total population and the DHB aims to bring these rates down in line with the rest of the population, because a number of factors can influence these rates this will take time, but it is positive to see change happening.*

Board's Report and Statutory Disclosure

To the stakeholders on the affairs of the Board for the year ended 30 June 2016.

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 $897k against the budgeted deficit of $878k (2014/15 result was a net deficit of $1.047m).

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	7	8	7	8	7
Kevin Brown	8	6			8	7		
Warren Gilbertson[a]	5	5	8	6				
Helen Gillespie	8	5	8	8				
Michelle Lomax	8	7					8	8
Peter Neame	8	7			8	8		
Sharon Pugh	8	8			8	6		
Elinor Stratford	8	8	8	8			8	8
Joseph Thomas[d]	8	7	8	5				
Francois Tumahai[b]	2	2						
John Vaile	8	8					8	5
Susan Wallace[c]	6	4	6	4				
Lynnette Beirne							8	6
Dr Cheryl Brunton							8	8
Jenny McGill							8	5
Mary Molloy							8	7
Joe Mason							8	6
Paula Cutbush					8	7		
Gail Howard					8	7		
Richard Wallace					8	5		
Chris Lim					8	7		

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

a Appointed November 2015
b Appointed April 2016
c Term ended April 2016
d Appointed Deputy Chair Nov 2015

BOARD FEES

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

	Year ended 30 June 2016		
	Board	Advisory Committee	Total
Board members			
Peter Ballantyne	33,600	1,750	35,350
Kevin Brown	16,320	1,938	18,258
Warren Gilbertson	9,520	1,500	11,020
Helen Gillespie	16,320	2,500	18,820
Michelle Lomax	16,320	2,000	18,320
Peter Neame	16,320	2,000	18,320
Sharon Pugh	16,320	1,813	18,133
Elinor Stratford	16,320	4,500	20,820
Joseph Thomas	18,700	1,250	19,950
Francois Tumahai	2,720	-	2,720
John Vaile	16,320	1,250	17,570
Susan Wallace	13,600	1,000	14,600
Advisory committee members			
Lynette Beirne (CPH&DSAC)	-	1,500	1,500
Dr Cheryl Brunton (CPH&DSAC)	-	-	-
Jenny McGill (CPH&DSAC)	-	1,250	1,250
Mary Molloy (CPH&DSAC)	-	1,750	1,750
Joe Mason (CPH&DSAC)	-	1,500	1,500
Paula Cutbush (HAC)	-	1,750	1,750
Gail Howard (HAC)	-	1,750	1,750
Richard Wallace (HAC)	-	1,250	1,250
Chris Lim (HAC)	-	1,750	1,750
	$192,380	**$34,000**	**$226,380**

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.

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 has arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensures 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 2016, 13 (2015: 3) employees received payments relating to the termination of their employment totalling $243,000 (2015: $300,000), excluding retiring gratuities paid out. The majority of payments relate to the closure of the 30 bed Kynnersley residential care facility in Buller. No Board members received compensation or other benefits in relation to cessation (2015: $nil).

REMUNERATION OF EMPLOYEES

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

	2016 Actual	2015 Actual
$100,000 - $109,999	22	21
$110,000 - $119,999	16	12
$120,000 - $129,999	6	6
$130,000 - $139,999	6	6
$140,000 - $149,999	3	4
$150,000 - $159,999	1	5
$160,000 - $169,999	2	1
$170,000 - $179,999	2	2
$180,000 - $189,999	-	-
$190,000 - $199,999	-	-
$200,000 - $209,999	2	1
$210,000 - $219,999	1	1
$220,000 - $229,999	-	1
$230,000 - $239,999	1	1
$240,000 - $249,999	-	1
$250,000 - $259,999	4	4
$260,000 - $269,999	2	3
$270,000 - $279,999	1	1
$280,000 - $289,999	2	2
$290,000 - $299,999	1	2
$300,000 - $309,999	1	2
$310,000 - $319,999	3	2
$320,000 - $329,999	2	2
$330,000 - $339,999	-	-
$340,000 - $349,999	1	-
$350,000 - $359,999	2	-
$360,000 - $369,000	-	2
$370,000 - $379,999	-	1
$380,000 - $389,000	1	0
$390,000 - $399,000	1	0
Total employees	**83**	**84**

83 employees (2015: 84) 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 83 employees shown, 77 are clinical employees (2015: 75) and are 6 non clinical employees (2015: 9).

Statutory Information

This Annual Report outlines the West Coast DHB's financial and non-financial performance for the year ended 30 June 2016. 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 Ethnicity	Number
Americas	6
Australian	9
British	25
Chinese	2
Filipino	6
Indian	20
Maori	30
Middle Eastern	2
New Zealand European	328
New Zealander	2
Not Stated / Don't Know	525
Other	4
Other African	2
Other Asian	6
Other European	10
Pacific Peoples	5
South African	5

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 Mix by Average Age	Average age
Medical	49.3
Nursing	51.3
Allied Health	51.3
Support	55.3
Management & Administration	50.0

Staff Mix by Gender	Number	Percentage
Female	846	85%
Male	141	15%
Total	987	

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.

Wellbeing, Health and Safety
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, which 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. Employees and their families are provided with free access to an Employee Assistance Programme if they are faced with work or personal issues that are negatively impacting on them. 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.

Equal Opportunities and Positive Behaviours
Consistent with our vision and organisational values, the West Coast DHB is committed to maintaining and enhancing practices which eliminate all forms of discrimination, bullying and harassment in the workplace and barriers to the recruitment, retention, development and promotion of its employees. West Coast DHB has a diverse, flexible and highly skilled workforce which reflects the demographics of its community and contributes significantly to the provision of quality, culturally and individually appropriate services. We are committed to identifying and dealing with all examples of bullying and harassment and have a zero tolerance policy in respect of such behaviour. All employees on joining the DHB are made familiar with our Bullying and Harassment Policy, Good Employer Policy and Equal Opportunities Policy.

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.

We are planning a new engagement survey in the near future.

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 People & Capability 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 (6 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.

Promoting open, user centric learning through a shared South Island e-learning platform called HealthLearn, is providing ready access to consistent and wide ranging learning. In addition, the online performance appraisal process ensures all employees are focussed on the right things and expected behaviours at an individual and team level. 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 2015/16 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 2016.

Signed on behalf of the Board:

Peter Ballantyne
Chair
28 October 2016

Helen Gillespie
Chair, Quality, Finance, Audit & Risk Committee
28 October 2016

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2016

In thousands of New Zealand dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Revenue				
Patient care revenue	2	140,316	140,677	138,699
Other operating revenue	3	646	720	645
Interest revenue	6a	327	528	517
Total revenue		141,289	141,925	139,861
Expenses				
Employee benefit costs	5	57,142	57,212	57,840
Depreciation and amortisation expense	8,9	4,572	4,740	4,238
Outsourced services	4a	7,284	5,112	7,255
Clinical supplies		7,781	7,404	7,736
Infrastructure and non-clinical expenses		8,673	8,956	9,836
Payments to other health service providers	4b	52,649	55,558	49,985
Other operating expenses	4c	2,456	2,309	2,514
Finance costs	6b	651	720	732
Capital charge	7	978	792	772
Total expenses		142,186	142,803	140,908
Net Surplus/(deficit)	14	**(897)**	**(878)**	(1,047)
Other comprehensive revenue & expenses				
Gain/(losses) on revaluation of land and buildings	14	-	-	2,513
Total other comprehensive revenue & expenses		-	-	2,513
Total comprehensive revenue & expenses		**(897)**	**(878)**	**1,466**

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

Statement of Changes in Net Assets/Equity

For the year ended 30 June 2016

In thousands of New Zealand dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Balance at 1 July		12,496	9,029	10,097
Total comprehensive revenue & expenses		(897)	(878)	1,466
Owner transactions				
Capital contributions from the Crown		878	1,000	1,000
Repayment of capital to the Crown		(68)	(68)	(67)
Balance at 30 June	14	**12,409**	**9,083**	**12,496**

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

Statement of Financial Position

As at 30 June 2016

In thousands of New Zealand dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Assets				
Current assets				
Cash and cash equivalents	12	11,850	10,201	5,718
Debtors and other receivables	11	5,941	4,218	11,099
Inventories	10	986	1,100	984
Patient and restricted funds	21	74	60	70
Assets held for sale	19	-	136	136
Total current assets		18,851	15,715	18,007
Non-current assets				
Property, plant and equipment	8	26,858	25,831	28,250
Intangible assets	9	1,248	1,206	1,575
Total non-current assets		28,106	27,037	29,825
Total assets		**46,957**	**42,752**	**47,832**
Liabilities				
Current liabilities				
Borrowings	15	3,500	3,250	3,250
Creditors and other payables	17	8,979	7,248	9,368
Employee entitlements and benefits	16	8,407	9,081	8,797
Patient and restricted trust funds	21	74	60	63
Total current liabilities		20,960	19,639	21,478
Non-current liabilities				
Borrowings	15	10,945	11,195	11,195
Employee entitlements and benefits	16	2,643	2,835	2,663
Total non-current liabilities		13,588	14,030	13,858
Total liabilities		**34,548**	**33,669**	**35,336**
Net Assets/Equity				
Contributed Capital	14	72,563	71,625	71,694
Revaluations	14	22,082	19,569	22,082
Accumulated surpluses/(deficits)	14	(82,236)	(82,150)	(81,319)
Trust funds		-	39	39
Total equity		12,409	9,083	12,496
Total equity and liabilities		**46,957**	**42,752**	**47,832**

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

Statement of Cash Flows

For the year ended 30 June 2016

In thousands of New Zealand dollars

	Note	2016 Actual	2016 Budget	2015 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health, patients and other revenue		146,076	141,397	125,754
Cash paid to suppliers		(72,307)	(75,199)	(60,581)
Cash paid to employees		(65,175)	(61,352)	(64,215)
Interest received		327	528	517
Interest paid		(651)	(720)	(668)
Goods and services tax (net)		767	-	210
Capital charge paid		(978)	(792)	(772)
Net cash flow from operating activities	13	8,059	3,862	245
Cash flows from investing activities				
Receipts/(Purchase) of investments		-	-	595
Purchase of property, plant and equipment		(2,693)	(3,858)	(3,135)
Purchase of intangible assets		(166)	-	(3)
Net cash flow from investing activities		(2,859)	(3,858)	(2,543)
Cash flows from financing activities				
Capital contributions from the Crown		1,000	1,000	1,101
Repayment of capital to the Crown		(68)	(68)	(68)
Repayment of loans		-	-	(500)
Net cash flow from financing activities		932	932	533
Net increase /(decrease) in cash and cash equivalents		6,132	936	(1,765)
Cash and cash equivalents at the start of the year		5,718	9,265	7,483
Cash and cash equivalents at the end of year	12	**11,850**	**10,201**	**5,718**

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.

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

Notes to the Financial Statements

For the year 30 June 2016

In thousands of New Zealand dollars

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 2016 and were authorised for issue by the Board on 28 October 2016.

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.

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 approved.

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 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.

The West Coast DHB reviews the useful lives and residual values of all of its property, plant and equipment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. The last assessment was undertaken in May 2015. There were no changes to the circumstances for the financial year ended June 2016.

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. 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.

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.

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 22.

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 budget figures of $0.878m deficit 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.

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 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 DHB 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

The West Coast DHB reviews the useful lives and residual values of all of its property, plant and equipment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. The last assessment was undertaken in May 2015. There were no changes to the circumstances for the financial year ended June 2016. 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

	2016 Actual	2015 Actual
Ministry of Health population based funding	122,033	119,700
Inter district flows	1,487	1,497
Ministry of Health other contracts	6,879	7,538
Accident Compensation Corporation	2,106	2,093
Other Patient Care Revenue	3,213	3,313
West Coast Primary Health Organisation	4,598	4,558
	140,316	**138,699**

3 Other operating revenue

	2016 Actual	2015 Actual
Donations received	9	4
Donated assets	-	58
Rental revenue	172	184
Training and Development	116	123
Home Based Support Services	73	73
Pharmacy	36	45
Insurance	8	7
Other	232	151
	646	**645**

4 (a) Outsourced services

	2016 Actual	2015 Actual
Outsourced personnel and services		
Medical and nursing services	5,787	5,452
Allied health services	6	(2)
Other services	1,491	1,805
	7,284	**7,255**

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

	2016 Actual	2015 Actual
Personal health and Maori health services	22,963	22,626
Mental health services	3,199	2,994
Public health services	377	363
Disability support services	8,640	8,516
Inter district patient outflows	17,470	15,486
	52,649	**49,985**

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	2016 Actual	2015 Actual
Impairment of debtors	11	1	27
Loss on disposal of property, plant and equipment		-	70
Audit fees (for the audit of the financial statements)		107	104
Audit related fees for assurance and related services (Internal and Quality Audits)		95	105
Board and advisory members fees		192	180
Operating lease expenses		555	626
Other		1,506	1,402
		2,456	**2,514**

5 Employee benefit costs

	2016 Actual	2015 Actual
Wages, salaries and other personnel costs	55,736	55,844
Contributions to defined contribution schemes	1,573	1,352
(Decrease)/increase in liability for employee entitlements	(410)	344
Restructuring expenses	243	300
	57,142	**57,840**

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

6 (a) Interest revenue

	2016 Actual	2015 Actual
Interest revenue	**327**	**517**

(b) Finance costs

	2016 Actual	2015 Actual
Interest expense	**651**	**732**

7 Capital charge

	2016 Actual	2015 Actual
Capital charge	**978**	**772**

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 2016 was 8% (2015: 8%).

8 Property, plant and equipment

15/16 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 2015	6,599	13,984	24,499	43	718	45,843
Additions	-	136	1,188	-	1,621	4,074
Disposals/transfers	-	(8)	(573)	-	(358)	(2,068)
Transfer from non-current assets held for sale	136	-	-	-	-	136
Balance at 30 June 2016	**6,735**	**14,112**	**25,114**	**43**	**1,981**	**47,985**
Depreciation						
Balance at 1 July 2015	-	-	(17,593)	-	-	(17,593)
Depreciation charge for the year	-	(2,416)	(1,665)	(7)	-	(4,088)
Disposals	-	8	547	-	-	555
Balance at 30 June 2016	**-**	**(2,408)**	**(18,711)**	**(7)**	**-**	**(21,126)**

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	(3,502)	-	(297)	-	(3,285)
Balance at 30 June 2015	**6,599**	**13,984**	**24,499**	**43**	**718**	**45,843**
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	-	5,499	-	301	-	5,800
Balance at 30 June 2015	**-**	**-**	**(17,593)**	**-**	**-**	**(17,593)**

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 2015	**6,599**	**13,984**	**6,906**	**43**	**718**	**28,250**
At 30 June 2016	**6,735**	**11,704**	**6,403**	**36**	**1,981**	**26,859**

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 14).

Impairment

Engineering reviews of Grey Base buildings during the 2013 financial year identified structures which are earthquake prone. For these structures, the West Coast DHB considered whether their carrying value exceeded their recoverable amount. As a result, the DHB recognised a $2.6m asset impairment at 30 June 2013. As at 30 June 2016, 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

	2016 Actual	2015 Actual
Software		
Cost		
Opening balance	4,141	4,152
Additions	163	2
Disposals	-	(13)
Closing balance	4,304	4,141
Amortisation		
Opening balance	(3,139)	(2,636)
Amortisation charge for the year	(484)	(516)
Disposals	-	13
Closing balance	(3,623)	(3,139)
NZ Health Partnerships Limited (formally Health Benefits Limited)	567	573
Carrying amounts	1,248	1,575

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 2016. There has been no change since last year.

The West Coast DHB has contributed $567,000 (2015: $573,000) New Zealand Health Partnerships Limited (NZHP), formally Health Benefits Limited, in relation to the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by NZHP, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

NZHP 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 NZHP 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 NZHP 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

	2016 Actual	2015 Actual
Pharmaceuticals	183	207
Surgical and medical supplies	788	759
Other supplies	15	18
	986	**984**

There were no write downs of inventories or reversal of prior year write-downs during the year (2015: $0). The amount of inventories recognised as an expense during the year ended 30 June 2016 was $1.593m (2015: $1.96m).

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 Debtors and other receivables

	Note	2016 Actual	2015 Actual
Trade receivables		902	1,857
Ministry of Health receivables		2,754	2,466
Other Crown receivables		1,329	6,020
Accrued revenue		566	407
Prepayments		390	349
	20	**5,941**	**11,099**

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 $0.878m (2015: $1m)

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

	Note	2016 Actual	2014 Actual
Balance 1 July		52	30
Receivables written off during the year		(1)	(3)
Impairment reversed		-	(2)
Additional provision made during the year	4c	1	27
Closing balance 30 June		**52**	**52**

12 Cash and cash equivalents

	Note	2016 Actual	2015 Actual
Bank balances and call deposits		11,850	5,718
Term deposits less than 3 months		-	-
Cash and cash equivalents in the statement of cash flows	20	**11,850**	**5,718**

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 21.)

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

	2016 Actual	2015 Actual
Deficit for the period	(897)	(1,047)
Add back non-cash items:		
Depreciation and amortisation expense	4,572	4,238
Remove non-cash revenue:		
Donated assets	-	(58)
Add back other items:		
Equity receivable	878	1,000
Movements in working capital:		
(Increase)/decrease in debtors and other receivables	4,280	(2,313)
(Increase)/decrease in inventories	(2)	26
Increase/(decrease) in creditors and other payables	(362)	(1,945)
Increase/(decrease) in employee benefits	(410)	344
Net movement in working capital	3,506	(3,888)
Net cash inflow/(outflow) from operating activities	**8,059**	**245**

14 Equity and reserves

Reconciliation of movement in equity and reserves	Crown equity	Property revaluation reserve	Trust/ Special funds	Accumulated surpluses/ (deficits)	Total equity
Balance at 1 July 2015	71,694	22,082	39	(81,319)	12,496
Surplus/(deficit) for the year				(897)	(897)
Capital contributions from the Crown	878	-	-	-	878
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	-	-	-	-	-
Other Movement/Adjustment	59		(39)	(20)	-
Balance at 30 June 2016	**72,563**	**22,082**	**-**	**(82,236)**	**12,409**
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	Note	2016 Actual	2015 Actual
Balance at beginning of year		39	39
Transfer from retained earnings in respect of:			
Interest received		-	-
Donations and funds received		-	-
Other adjustments		(39)	-
Transfer to retained earnings in respect of:		-	-
Funds spent		-	-
Balance at end of year		**0**	**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

15 Borrowings

Secured loans

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

	Note	2016 Actual	2015 Actual
Non-current			
Ministry of Health	20	10,945	11,195
		10,945	**11,195**
Current			
Ministry of Health	20	3,500	3,250
		3,500	**3,250**

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	2016 Actual	2015 Actual
Repayable as follows:			
Within one year		3,500	3,000
Weighted average effective interest rate		2.24%	4.75%
Later than one year but not more than five years		4,695	5,195
Weighted average effective interest rate		5.22%	4.97%
Later than five years		6,250	6,250
Weighted average effective interest rate		3.98%	3.98%
	20	**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 an agreement with the Ministry of Health that ensures 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.

16 Employee entitlements and benefits

	2016 Actual	2015 Actual
Non-current liabilities		
Liability for long-service leave	651	623
Liability for sabbatical leave	80	65
Liability for retirement gratuities	1,912	1,975
	2,643	**2,663**
Current liabilities		
Liability for long-service leave	248	232
Liability for retirement gratuities	511	570
Liability for annual leave	3,937	3,867
Liability for other leave	1,505	1,463
Liability for sick leave	118	92
Liability for continuing medical education/ sabbatical leave	656	874
Salary and wages accrued	1,432	1,699
	8,407	**8,797**

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 2 May 2016.

17 Creditors and other payables

	Note	2016 Actual	2015 Actual
Trade payables		6,663	7,498
ACC levy payable		355	544
GST and PAYE tax payable		1,906	1,303
Revenue in advance		55	23
	20	**8,979**	**9,368**

Creditors 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.

18 Commitments

	2016 Actual	2015 Actual
Total capital commitments at balance date	**435**	**499**
Non-cancellable operating lease commitments		
Not more than one year	110	126
One to two years	48	54
Two to three years	-	61
Total non-cancellable operating lease and supply commitments	**158**	**240**

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.

19 Non-current assets held for sale

In the financial year to June 2015 there were assets (land) that the West Coast DHB identified as surplus to requirements; these were shown as assets held for sale (measured at a book value of $136,650). In the financial year to June 2016, there has been no activity to dispose of these assets, and it is considered that these no longer meet the probability criteria required of assets held for sale; therefore these assets have been reclassified.

20 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 2016 (2015: nil)

Interest rate risk
The interest rates on borrowings are disclosed in note 15.

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 25).

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry, which comprises 46% (2015: 22%) of the debtors of the West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHB) total reliance on Government debtors is 69% (2015: 76%). The Ministry of Health, as the government funder of health and disability support services for the West Coast region and other Crown entities are high credit quality entities and the Board considers the risk arising from this concentration of credit to be very low.

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

Trade Receivables

	Note	Gross Receivable 2016	Impairment 2016	Net 2016	Gross Receivable 2015	Impairment 2015	Net 2015
Due 0-30 days		5,241	-	5,241	9,939	-	9,939
Past due 31-60 days		20	-	20	56	-	56
Past due 61-90 days		34	-	34	22	-	22
Past due more 90 days		308	(52)	256	785	(52)	733
Total Gross Receivables	11	**5,603**	**(52)**	**5,551**	**10,802**	**(52)**	**10,750**

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 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 NZHP facility where NZHP invest funds until required. The rate of interest for call funds at 30 June 2016 was 2.88% (2015: 3.94%).

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

	Note	2016 Actual	2015 Actual
Cash			
AA-	12	72	(129)
Term Deposits - Patient and Restricted Funds			
AA-	21	74	70
Total Cash and Term Deposits		**146**	**(59)**

Counterparties without credit rating

	Note	2016 Actual	2015 Actual
Balance with New Zealand Health Partnership			
Existing counterparty with no defaults in the past	12	11,778	5,847
Total balance with New Zealand Health Partnership		**11,778**	**5,847**
Debtors and other receivables			
Existing counterparty with no defaults in the past	11	5,941	11,099
Total debtors and other receivables		**5,941**	**11,099**

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.

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
2016						
Secured Ministry of Health loans	14,445	14,445	3,500	-	4,695	6,250
Creditors and other payables	8,979	8,979	8,979	-	-	-
Total	**23,424**	**23,424**	**12,479**	**-**	**4,695**	**6,250**
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**

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 2016 Actual	Fair value 2016 Actual	Carrying amount 2015 Actual	Fair value 2015 Actual
Patient and Restricted Funds	21	74	74	70	70
Debtors and other receivables	11	5,941	5,941	11,099	11,099
Cash and cash equivalents	12	11,850	11,850	5,718	5,718
		17,865	**17,865**	**16,887**	**16,887**
Secured loans	15	14,445	15,169	14,445	15,169
Creditors and other payables	17	8,979	8,979	9,368	9,368
		23,424	**24,148**	**22,813**	**24,537**
Unrecognised (losses)/gains		**-**	**724**	**-**	**724**

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 approved.

Categories of financial assets and liabilities

	Note	2016 Actual	2015 Actual
Loans and receivables			
Cash and cash equivalents	12	11,850	5,718
Patient and Restricted Funds	21	74	70
Debtors and other receivables	11	5,941	11,099
		17,865	**16,887**
Financial liabilities			
Creditors and other payables	17	8,979	9,368
Borrowings-secured loans	15	14,445	14,445
		23,424	**23,813**

21 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.

	Note	2016 Actual	2015 Actual
Opening balance patients deposits		63	54
Monies received		-	8
Interest earned		4	1
Payments made		-	-
Closing balance		**67**	**63**

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

	Note	2016 Actual	2015 Actual
Opening balance restricted funds		7	7
Monies received		54	-
Interest earned		-	-
Payments made		(54)	-
Closing balance		**7**	**7**

22 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 (2015: nil).

23 Related parties

The West Coast DHB is a wholly owned entity of the Crown. All related party transactions have been entered into on an arm's length basis.

Significant transactions with government related entities
The West Coast DHB has received funding from the Crown, ACC and other government entities of $131.27m to provide health services in the West Coast area for the year ended 30 June 2016 (2015: $134.17m).

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 $1.56m for the year ended 30 June 2016 (2015: $1.53m). Expenditure to other DHBs for the care of patients from the West Coast DHB's district and services provided from other DHBs amounted to $18.52m for the year ended 30 June 2016 (2015: $18.00m).

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 2016 totaled $1.912m (2015: $2.244m). 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

	2016		2015	
	FTE	Actual	FTE	Actual
Short-term employee benefits-executive management	5	1,031	4	717
Post-employment benefits		13		12
		1,044		**729**

The executive management team consisted of 5 members (2015: 4) employed by West Coast DHB and a further 6 members, including the Chief Executive, who were employed by Canterbury DHB (2015: 6). The key management personnel services provided by the Office of the Chief Executive are provided to West Coast DHB under contract by Canterbury DHB and are invoiced accordingly- 2016: $300k (2015: $300,000). For the year under review, no executive management personnel were Board members (2015: 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.

24 Events after balance date

There were no events after 30 June 2016 which could have a material impact on the information in West Coast DHB's financial statements.

25 Bank facility

West Coast DHB is a party to the "DHB Treasury Services Agreement" between New Zealand Health Partnership Limited (NZHP) and the participating DHBs. This Agreement enables NZHP to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at credit interest rate received by NZHP 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 the West Coast DHB this equates to $5.943m.

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.

26 Major variances to budget

Statement of Comprehensive Revenue and Expense
The financial result for the full financial year to June 2016 is a deficit of $0.897m, which is $0.019m over the approved deficit of $0.878m.

There are no major revenue variances to budget.

The major expense variance to budget is in Outsourced Services, principally outsourced medical personnel (locum) costs in the Provider which were $1.66m above budget. Locum costs continue to be incurred for a number of reasons, with the major driver continuing to be the difficulties in recruitment and retention of all medical staff from RMOs to GPs. While every effort is made to mitigate locum costs, the issues with the level of Locum payments are part of the challenges of the operating environment for the West Coast DHB.

Funder payments to external providers for rest homes and community residential beds are favourable to budget by $0.48m following the closure of the 30 bed Kynnersley residential care facility. The reduction in spend has been partially offset in the Funder by the increase in the commitment to home support with the establishment of a rehabilitation support team. Pharmaceuticals are $0.838m lower than budget due to the continued revision of on-going Pharmacy costs and the level of Pharmac rebates.

Statement of Changes in Equity
No major variances to budget in the Statement of Changes in Equity for the year ended 30 June 2016.

Statement of Financial Position
In the financial year to June 2015 there were assets (land) that the West Coast DHB identified as surplus to requirements; these were shown as assets held for sale (measured at a book

value of $136,650). In the financial year to June 2016, there has been no activity to dispose of these assets, and it is considered that these no longer meet the probability criteria required of assets held for sale; therefore these assets have been reclassified.

Statement of Cash Flows
The balance of the cash and cash equivalents at the end of the year was $1.6m above budget which reflects the new timeframes for facility redevelopment capital expenditure.

27 Revenue Appropriation

Under the Public Finance Act, the DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by the DHB for the financial year 2015/16 is $124,072,184 which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 6 to 26.

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 2016. 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.

	2016 Actual	2016 Budget
Revenue		
Prevention	2,906	2,962
Early Detection and Management	27,337	27,819
Intensive Assessment and Treatment	91,568	91,658
Rehabilitation and Support	19,478	19,486
Total Revenue	**141,289**	**141,925**
Expenditure		
Prevention	3,028	3,010
Early Detection and Management	27,418	27,958
Intensive Assessment and Treatment	92,605	92,359
Rehabilitation and Support	19,135	19,476
Total Expenditure	**142,186**	**142,803**
Surplus/ (Deficit)	**(897)**	**(878)**

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.

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 2016

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, including the performance information for appropriations, of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 36 to 65, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 6 to 26, and 66.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 36 to 65:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; 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 Public Benefit Entity Reporting 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 practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 6 to 26, and 66:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2016, 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;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 28 October 2016. 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 Public Benefit Entity Reporting 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 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