WEST COAST DISTRICT HEALTH BOARD

Te Poari Hauora a Rohe o Tai Poutini

ANNUAL REPORT

FOR THE YEAR ENDED
30 JUNE 2005

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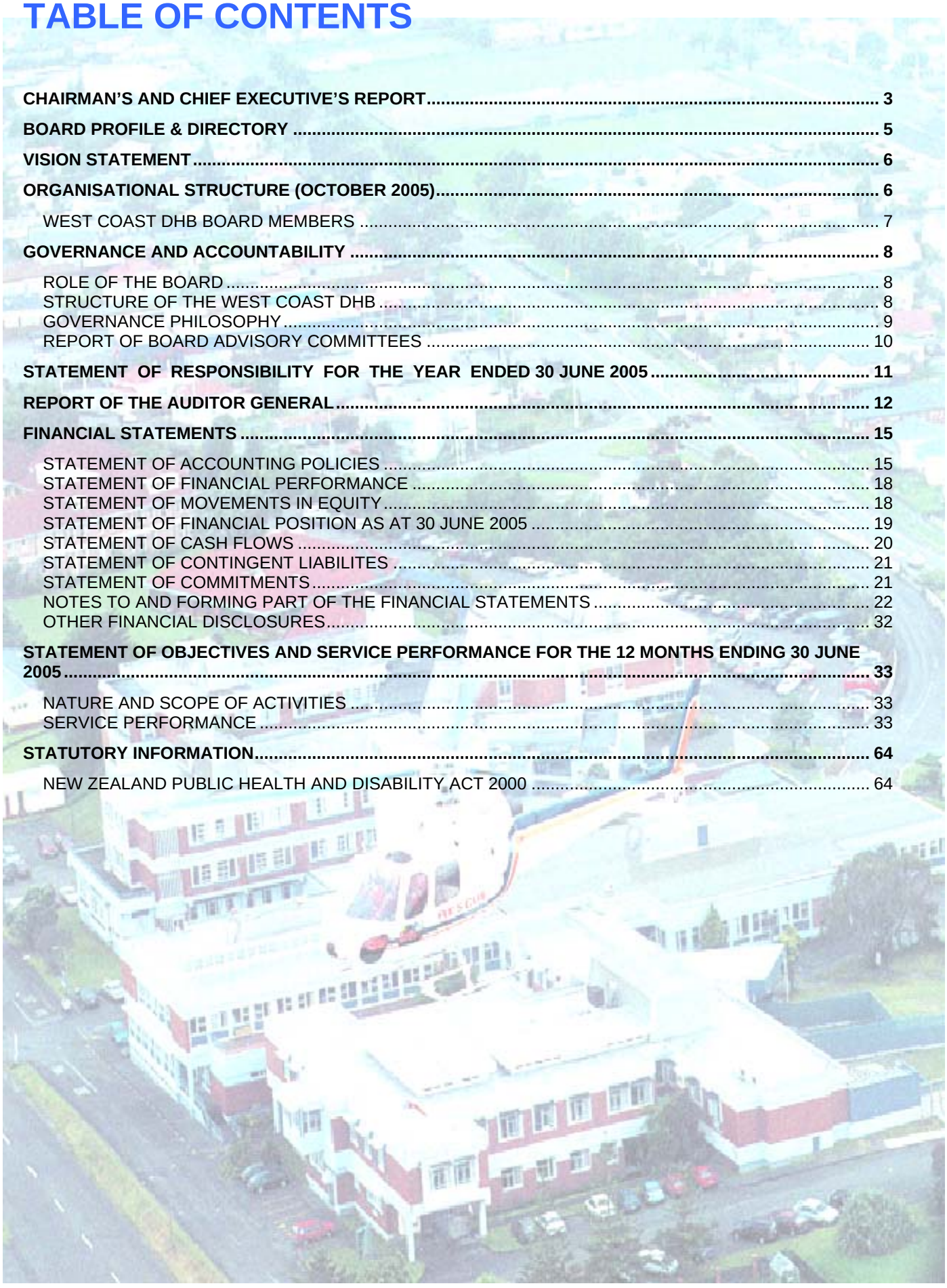


CHAIRMAN'S AND CHIEF EXECUTIVE'S REPORT

Over the past year the West Coast District Health Board has overcome a number of challenges to have one of its most successful years to date.

The Board has fulfilled its obligations for the delivery of elective services. In addition, the Board has performed within budget for the fourth successive year in a row. Full credit for this success must go to the Board, management and staff who have worked particularly hard to achieve these objectives.

Recruitment and retention of staff remains one of the organisation's biggest challenges. The West Coast DHB works closely and collaboratively with other DHBs and particularly with Canterbury, Nelson-Marlborough and Otago DHB, for clinical service delivery, and in shared administration functions. For example, to ensure ongoing clinical development of staff and to further aid recruitment and retention, the West Coast DHB and Canterbury DHB are collaborating closely on opportunities for surgeons from Christchurch to travel to this region and work. This is aimed at increasing the peer support available to surgeons and other specialists working on the West Coast but will also hopefully allow increasing numbers of people in this region to receive surgery in the region.

This year a number of West Coast patients also began receiving chemotherapy in the region, where as they had previously only been able to receive the treatment outside of the West Coast. There are currently no people on the chemotherapy waiting list and there is no waiting time for those eligible to receive their treatment here, something of which this region can be truly proud.

The West Coast has also joined the national Meningococcal B immunisation campaign. In total the DHB hopes that around 8500 children and young people will be vaccinated against this devastating disease.

This year the West Coast DHB became the sixth rural training centre for the Dunedin School of Medicine. Fifth year medical students now have the option of undertaking training in this region. The DHB hopes by exposing students to the region we can encourage them to return once they have completed their training.

The past 12 months has seen the DHB shift from simply keeping up with technology to spending over $2 million upgrading and introducing Information Technology. PrISM, a West Coast initiative has been rolled out from Karamea to Fox Glacier, connecting electronically all the DHB primary care sites together. Both patients and clinical staff benefit from having more effective and faster access to information. This system not only delivers the right patient information at the right time and in the right place but also can help increase continuity of care by allowing primary care providers to access patient information.

Whilst the West Coast must compete on both a national and international level to attract professionals the organisation feels that through innovations such as its new computer system and closer working ties with CDHB, it is on the right track to providing a working environment that offers the latest and best technology.

In financial terms the West Coast DHB achieved a result $1,004,000 better than budget recording a deficit of $1.68 million dollars. The DHB came in under budget even after allowances were made for the introduction of the Holidays Act and the nursing Multi Employer Collective Agreement (MECA) pay jolt.

This past year also saw the resignation of Chief Executive John Luhrs who left the organisation to take-up a career opportunity in Auckland, after three and a half years at the helm. Glenys Baldick temporarily stepped down from her position on the Board in order to take-up the Acting Chief Executive position leading the organisation through a seamless transition before handing over the reins to Kevin Hague. Kevin takes over at a time when the organisation is moving in an increasingly positive direction. The announcement that the Board will receive an additional $2.68 million in the next financial year has meant it is now planning for its first break-even year.

The DHB is also currently working closely with the regions three district councils on various projects, including a health centre concept in Greymouth, improving local input into Buller Medical Services and the provision of dental services in Westland, which it hopes will benefit the region for many years to come.

While the past year has seen a number of changes in senior management, the Board has also undergone some changes after September's local body elections. All but one Board member were returned to their positions and were joined by newly elected members Dr Carol Atmore and Brian Wilkinson.

The West Coast DHB believes it offers services that are comparable to any region in New Zealand and that is largely due to the dedication and professionalism shown by every person working in health in this region. We would like to thank the community of the West Coast for your input. The comments and suggestions that you made during this year's District Strategic Plan process were valued and will be used to help this organisation set its priorities.

In this brief overview we have only been able to mention a few of the highlights of the past year. It is also important to acknowledge the huge amount of work that goes into running health services in this region on a day-to-day basis. The fact our patient satisfaction ratings are consistently amongst the best in the country is testament to the level of care the people of the West Coast receive. To our Board, committee members, management and all staff we acknowledge your support and thank you for your significant contributions.

Professor Gregor Coster
Chairman

Kevin Hague
Chief Executive Officer

BOARD PROFILE & DIRECTORY

BOARD MEMBERS

Professor Gregor Coster, Chairman
Dr Christine Robertson, Deputy Chair
Mrs Glenys Baldick
Mr Mohammed Shahadat
Dr Malcolm Stuart
Ms Robyne Bryant
Mrs Julie Kilkelly
Dr Carol Atmore
Mr John Vaile
Mr Brian Wilkinson

CHIEF EXECUTIVE

Kevin Hague

Email: ceo@westcoastdhb.org.nz

REGISTERED OFFICE

Corporate Office
High Street
GREYMOUTH

Telephone: (03) 768 0499
Facsimile: (03) 768 2791

POSTAL ADDRESS

PO Box 387
GREYMOUTH

WEBSITE

www.westcoastdhb.org.nz

AUDITOR

Audit New Zealand on behalf of the
Auditor-General

BANKERS

Crown Health Financing Agency

Bank of New Zealand

SOLICITORS

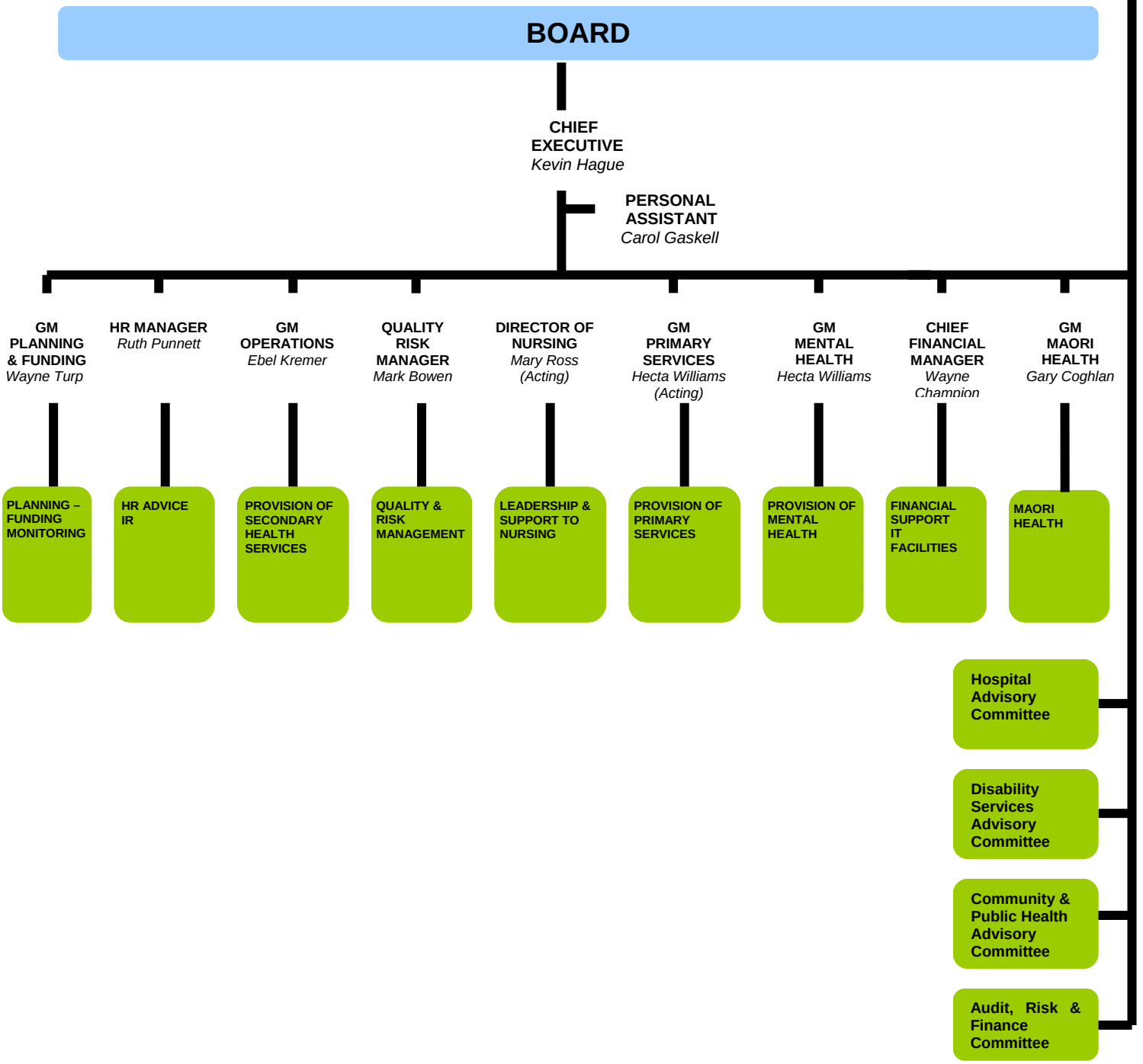
Hannan & Seddon
Guinness Street
GREYMOUTH

Telephone: (03) 768 4169

VISION STATEMENT

"To fund a continuum of quality health services aimed at providing improved health outcomes and maximising the independence of people with disabilities"

ORGANISATIONAL STRUCTURE (OCTOBER 2005)



WEST COAST DHB BOARD MEMBERS

Board Member	Current Interests	Special Responsibilities
Professor Gregor Coster ***Re-appointed October 2004***	• Director - PHARMAC • Director - Cornwall Management Limited	• Board Chairman • Member - HAC • Member - CPHAC • Member - DSAC
Dr Christine Robertson ***Re-appointed 1 December 2004***	As self employed person, does work on contract for: • HealthPAC - regularly Husband is Deputy Chair of the Board of Coast Care Trust and is a Justice of the Peace who undertakes judicial duties in Court. Also Alternate Controller for Civil Defence for the Grey District Council.	• Board Deputy Chairman • Chair - HAC • Member - Audit, Risk & Finance Committee
Glenys Baldick ***Appointed 1 December 2004 Stood down to act as Acting Chief Executive from 7 March 2005 to 30 July 2005***	• Chairman - Health Sector Welfare Society • Chairman - Junior Doctors' Round Table • Trustee - Nelson Hospital Equipment Trust	• Member - HAC
Ms Robyne Bryant ***Elected Member November 2004***	• Trustee - Board of Coast Care Trust • Employed by WCDHB as a midwife on a casual basis	• Member - Audit, Risk & Finance Committee • Member - CPHAC
Mrs Julie Kilkelly ***Elected Member November 2004***	• Member - Pharmaceutical Society • Member - New Zealand College of Pharmacists • Director - Kilkelly Kartage Ltd • Trustee - West Coast PHO Board • Director - Olsen's Pharmacy (2002) Ltd	• Chair - CPHAC
Mr Mohammed Shahadat ***Elected Member November 2004***	• Principal Partner - Murdoch James and Roper • Trustee - West Coast Development Trust	• Chair - Audit, Risk & Finance Committee • Member - DSAC
Dr Malcolm Stuart ***Elected Member November 2004***	• Employed by WCDHB as Head of Department, Anaesthesia and Consultant Anaesthetist • National Committee - Australian New Zealand College of Anaesthetists • Member - Association of Salaried Medical Staff As a self employed person: • Medical Advisor - St John Ambulance Service	
Mr John Vaile ***Elected Member November 2004***	• Director - Vaile Hardware Ltd • Wife has an unresolved employment matter with WCDHB	• Chair – DSAC
Dr Carol Atmore ***Elected Member November 2004***	• Employed by WCDHB as a General Practitioner at Greymouth Medical Centre and as GP Liaison Officer • Member - South Link Health	
Mr Brian Wilkinson ***Elected Member November 2004***	• Member – Pharmaceutical Society • Justice of the Peace • Trustee - West Coast Development Trust	• Member - HAC

GOVERNANCE AND ACCOUNTABILITY

ROLE OF THE BOARD

The Board's governance responsibilities include:

- Communicating with the Minister and other stakeholders to ensure their views are reflected in the West Coast District Health Board's (DHB's) planning.
- Delegating responsibility for achievement of specific objectives to the Chief Executive.
- Monitoring organisational performance towards achieving its objectives.
- Reporting to stakeholders on plans and progress against them.
- Maintaining effective systems of internal control.

STRUCTURE OF THE WEST COAST DHB

West Coast DHB Operations

The Board has appointed a single employee, the Chief Executive to manage all West Coast DHB operations. The Chief Executive has appointed all other employees of the West Coast DHB. The Board directs the Chief Executive by delegating responsibility for the achievement of objectives through setting policy.

Board Committees

The Board has set up several standing committees to provide a more detailed level of focus on particular issues. Each committee has been delegated responsibility for governance; that is advising the Board on policies and monitoring of the organisation's progress towards meeting the West Coast DHB's objectives. Committees do not involve themselves in operational matters. The Board's standing committees (including the statutory permanent advisory committees) are:

Committee Meets

Audit, Risk & Finance Committee	Quarterly
Hospital Advisory Committee	2 monthly
Community & Public Health Advisory Committee	2 monthly
Disability Services Advisory Committee	2 monthly

Quality Assurance

The Board has always had its own Provider Arm and its processes are well developed. The Board has always had an administrative (governance) function, but the structure and role has changed significantly with the addition of the funder role.

The West Coast DHB continues to ensure the ongoing development of high quality care and service that will ensure continuous quality improvement is achieved throughout the organisation.

- West Coast DHB has pursued clinical effectiveness and quality assurance gains for all its services. This has been achieved through the development of an annual quality plan, which enables a focused approach to quality improvement to be facilitated throughout the organisation, and ensures the development of a supportive quality improvement culture and organisation-wide commitment to the principles of quality improvement.
- West Coast DHB has sought to ensure that clinical effectiveness and quality is promoted throughout the organisation, and that clinically acceptable standards are maintained.
- West Coast DHB has made available a designated resource to develop, implement and monitor the annual quality plan that takes account of the requirements for clinical effectiveness and quality improvement.
- West Coast DHB operates a system of patient satisfaction surveys that provide opportunities for seeking patient input and provides a means of linking organisational obligations with patient requirements.

Subsidiaries and Associations

The Board has a minority shareholding in:

- The South Island Shared Services Agency Limited

The South Island Shared Services Agency Limited is owned by the six South Island DHBs and provides them with support services around their health planning and funding roles.

Board Membership

All Board members are required to act in the best interests of the West Coast DHB. Members acknowledge that the Board must stand unified behind its decisions; individual members have no separate governing role outside the Board room.

Connection with Stakeholders

The Board acknowledges its responsibility to keep in touch with stakeholders and in particular remain cognisant of the Minister's expectations.

Division of Responsibility between the Board and Management

Key to the efficient running of the West Coast DHB is that there is a clear division between the roles of the Board and management. The Board concentrates on setting policy, approving strategy, and monitoring progress toward meeting objectives. Management is concerned with implementing policy and strategy. The Board has clearly distinguished these roles by ensuring that the delegation of responsibility and authority to the Chief Executive is concise and complete.

Accountability

The Board holds six weekly meetings to monitor progress toward its strategic objectives and to ensure that the affairs of the West Coast DHB and its subsidiaries are being conducted in accordance with the West Coast DHB's policies.

Conflicts of Interest

The Board maintains an interests' register and ensures Board members are aware of their obligations to declare any potential conflicts of interest.

Internal Audit

While many of the Board's functions have been delegated, the overall responsibility for maintaining effective systems of internal control ultimately rests with the Board. Internal controls include the policies, systems and procedures established to provide assurance that specific objectives of the Board will be achieved. The Board and management have acknowledged their responsibility by signing the Statement of Responsibility on page 12 of this report.

The West Coast DHB has an internal audit function, which is responsible for monitoring its systems of internal control and the quality and reliability of financial and non financial information reported to the Board. Internal Audit operates independently of management and reports its findings directly to the Audit Committee. Internal Audit liaises closely with the external auditors, who review the systems of internal control to the extent necessary to support their audit opinion.

Risk Management

The Board acknowledges that it is ultimately responsible for the management of risks to the West Coast DHB. The Board has charged the Chief Executive through its risk management policy with establishing and operating a risk management programme in accordance with the "Guidelines for Managing Risk in the Australian and New Zealand Public Sector SAA / NZSHB 143:1999".

Legislative Compliance

The Board acknowledges its responsibility to ensure the organisation complies with all legislation. The board has delegated responsibility to the Chief Executive for the development and operation of a programme to systematically identify compliance issues and ensure that all staff are aware of legislative requirements that are particularly relevant to them.

Ethics

The Board has adopted a code of ethics and regularly monitors whether staff maintain high standards of ethical behaviour and practice the principles of "good corporate citizenship."

Monitoring compliance with ethical standards is done through such means as monitoring trends in complaints and disciplinary actions; internal audit reports; or any reports or indications that show non-conformance with the principles espoused in the code of ethics.

Good corporate citizenship involves this entity, including its employees, acknowledging that it is a member of one or more communities outside of itself, and making a commitment to act in a manner consistent with the social morals and accepted rights and responsibilities of all citizens of those communities.

REPORT OF BOARD ADVISORY COMMITTEES

The West Coast DHB has three advisory committees, their existence being a requirement of the New Zealand Public Health and Disability Act 2000. These are the Hospital Advisory Committee (HAC), the Disability Services Advisory Committee (DSAC) and the Community and Public Health Advisory Committee (CPHAC).

The functions of the statutory committees are as outlined in the New Zealand Public Health and Disability Act 2000.

Essentially, the advisory committees are charged with providing advice on the health needs of the resident West Coast population with CPHAC having a focus on health status and DSAC focussing on the support needs of people with physical disabilities. The committees must also provide advice on prioritising the use of the health funding provided for the purpose of service provision.

HAC has a more specific role in that it must monitor the financial and operational performance of the hospitals and related services, assess any strategic issues relating to the provision of these services, and provide advice as a result of the monitoring and assessment.

All committees are advisory with the requirement that any advice given to the Board of the DHB must be consistent with the New Zealand Health Strategy. The Board remains the sole decision making body while taking cognisance of the recommendations and advice it receives from its committees.

Membership of all committees comprises a mix of DHB Board members, ex officio members and community appointees. Board members were selected by their colleagues to sit on the committees. The Chair of the Board is an ex officio member of all advisory committees while other ex officio members have been appointed because of the particular skills and experience they bring to any committee. Community members were appointed, having been selected from people who had responded to Coast wide advertising for interested parties. Selection was on the basis of the skills and experience identified by the DHB as being necessary for such appointees and included the areas of finance, governance and health or related service provision. Where there were two or more applicants with similar qualities, selection then took account of geographic considerations.

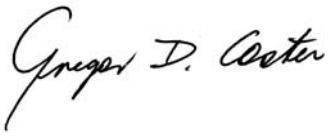
The Chairs of all committees recognise the considerable input from staff and wish to record their thanks for work well done.

STATEMENT OF RESPONSIBILITY FOR THE YEAR ENDED 30 JUNE 2005

1. The Board and management of the West Coast DHB accept responsibility for the preparation of the annual Financial Statements and the judgements used in them.

2. The Board and management of the West Coast DHB accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non financial reporting.

3. In the opinion of the Board and management of the West Coast DHB, the annual Financial Statements for the year ended 30 June 2005, fairly reflect the financial position and operations of the West Coast DHB.



Professor Gregor Coster
Chairman

Kevin Hague
Chief Executive Officer

Wayne Champion
Chief Financial Manager

REPORT OF THE AUDITOR GENERAL

Audit New Zealand

AUDIT REPORT

TO THE READERS OF
WEST COAST DISTRICT HEALTH BOARD'S
FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2005

The Auditor-General is the auditor of West Coast District Health Board (the Health Board). The Auditor-General has appointed me, Devan Menon, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health Board, on his behalf, for the year ended 30 June 2005.

Unqualified opinion

In our opinion the financial statements of the Health Board on pages 15 to 62:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health Board's financial position as at 30 June 2005;
  - the results of its operations and cash flows for the year ended on that date; and
  - its service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 21 October 2005, and 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 the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements.

We evaluated the overall adequacy of the presentation of information in the financial statements. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the auditor

The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board as at 30 June 2005. They must also fairly reflect the results of its operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

In addition to the audit we carried out two assurance related assignments for the Health Board. These assignments related to the reviews of the Statement of Intent and the adequacy of the Health Board's policies and procedures for identifying and managing conflicts of interest. These assignments are compatible with those independence requirements.

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

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

This audit report relates to the financial statements of West Coast District Health Board (the Board) for the year ended 30 June 2005 included on the Board's web-site. The Board's Members are responsible for the maintenance and integrity of the Board's web site. We have not been engaged to report on the integrity of the Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 21 October 2005 to confirm the information included in the audited financial statements presented on this web site.

Legislation in New Zealand governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

FINANCIAL STATEMENTS

STATEMENT OF ACCOUNTING POLICIES

FOR THE YEAR ENDED 30 JUNE 2005

Wayne Champion
Chief Financial Manager

REPORTING ENTITY

The West Coast DHB is a Crown entity in terms of the Public Finance Act 1989.

The financial statements of the West Coast DHB have been prepared in accordance with the requirements of the New Zealand Public Health & Disability Act 2000, Public Finance Act 1989 and Crown Entities Act 2004.

MEASUREMENT BASE

The financial statements of the West Coast DHB have been prepared on an historical cost basis, modified by the revaluation of certain assets.

ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of financial results and financial position, have been applied:

Budget Figures

The budget figures are those approved by the Board and published in its District Annual Plan. 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.

Goods and Services Tax

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.

Taxation

The West Coast DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Trust and Bequest Funds

Donations and bequests to 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 Statement of Financial Performance and an equivalent amount is transferred from the Trust Funds component of Equity to Retained Earnings.

Accounts Receivable

Accounts Receivable are stated at expected realisable value after providing for doubtful and uncollectible debts.

Inventories

Inventories are stated at the lower of cost and net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

Investments

Investments are stated at the lower of cost and net realisable value. Any write-downs are recognised in the Statement of Financial Performance.

Properties Intended for Sale

Properties intended for sale are valued at the lower of cost (or book value) or net realisable value. Properties intended for sale (excluding land) have depreciation applied on a straight-line basis.

Fixed Assets

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

Fixed Assets Acquired Since the Establishment of the District Health Board

Assets, other than land and buildings, acquired by the Board since its establishment, and other than those vested from the Hospital and Health Service, are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisitions and installation including materials, labour, direct overheads, financing and transport costs.

Revaluation of Land and Buildings

Land and buildings are revalued every three years to their fair value as determined by an independent registered valuer by reference to their highest and best use. Additions between revaluations are recorded at cost. The results of revaluing land and buildings 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 statement of financial performance.

Disposal of Fixed Assets

When a fixed asset is disposed of, any gain or loss is recognised in the Statement of Financial Performance and is calculated at the difference between the sale price and the carrying value of the fixed asset.

Depreciation

Depreciation is provided on a straight-line basis on all assets with a cost or valuation above $2000, at rates, which will write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives. Assets below $2000 are written off in the month of purchase. The estimated useful lives of major classes of assets are as follows:

	Years
Freehold Buildings	5 – 50
Fit Out Plant & Equipment	5 – 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.

Employee Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, medical education leave and sabbatical leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

Leased Assets

Finance Leases

Leases which effectively transfer to the 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 DHB is expected to benefit from their use.

The Public Finance Act requires DHBs to obtain approval from the Minister of Health prior to entering a finance lease arrangement.

All existing finance leases were undertaken by Coast Health Care Ltd, before the establishment of the West Coast DHB and before the requirement for Ministerial approval came into effect.

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 on a systematic basis over the period of the lease.

Financial Instruments

The DHB is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short-term deposits, investments, debtors, creditors and loans. All financial instruments are recognised in the Statement of Financial Position and all revenues and expenses in relation to the financial instruments are recognised in the Statement of Financial Performance.

Except for loans, which are recorded at cost, and those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, bank overdrafts and demand deposits in which the DHB invests as part of its day-to-day cash management.

Operating activities include all transactions that are not investing or financing activities. Cash inflows include all receipts from the sale of goods and services and other sources of revenue, which supports the Board's operating activities. Cash outflows include the payments made to employees, suppliers and for taxes.

Investing activities are those activities relating to the acquisition and disposal of current and non-current securities and advances and any other non current assets.

Financing activities comprise the change in equity and debt capital structure of the DHB.

Cost of Service Statements

The cost of service statements presented in the statement of objectives and service performance report the net cost of services for the outputs of the West Coast DHB and represent the cost of providing the output less all the revenue that can be directly attributed to these activities.

Cost Allocation

West Coast DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to each output class.

All indirect costs are charged to the provider, as they mostly relate to the costs of providing hospital and health service infrastructure.

An estimation of the proportion of Governance activities that is attributed to the Provider is charged to the provider output class.

CHANGE IN ACCOUNTING POLICIES

There have been no changes from the accounting policies adopted in the last audited financial statements. All policies have been applied on a basis consistent with the previous year.

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Budget June 2005 $000	Actual June 2005 $000	Actual June 2004 $000
Revenue		84,256	83,174	78,258
Expenses (excluding capital charge)		85,636	83,902	77,377
Capital charge	16	1,300	948	1,319
OPERATING DEFICIT	1	(2,680)	(1,676)	(438)
NET DEFICIT		(2,680)	(1,676)	(438)

STATEMENT OF MOVEMENTS IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2005

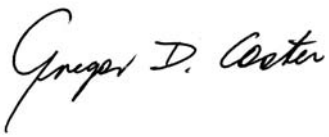
	Notes	Budget June 2005 $000	Actual June 2005 $000	Actual June 2004 $000
EQUITY AT BEGINNING OF THE PERIOD		13,880	13,880	12,240
Net deficit for the year		(2,680)	(1,676)	(438)
Movement in Asset Revaluation Reserve	3(d)		9	-
Total recognised revenues and expenses for the period		(2,680)	(1,667)	(438)
OTHER MOVEMENTS				
Contributions from owners	3(a)	3,680	1,000	2,078
EQUITY AT THE END OF THE PERIOD		14,880	13,213	13,880

The accompanying statement of accounting policies on pages 15 to 17, and notes on pages 22 to 31 form part of these financial statements.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2005

	Notes	Budget June 2005 $000	Actual June 2005 $000	Actual June 2004 $000
EQUITY				
Share Capital	3(a)	46,827	44,147	43,147
Retained earnings/(Accumulated Deficit)	3(b)	(40,535)	(39,527)	(37,853)
Trust funds	3(c)	45	41	43
Asset Revaluation Reserve	3(d)	8,543	8,552	8,543
Total equity		14,880	13,213	13,880
REPRESENTED BY:				
ASSETS				
Current assets				
Cash		1,714	3,672	5,012
Short term Investment		-	3,400	1,250
Receivables and prepayments	4	6,966	6,299	6,557
Inventories	5	578	597	578
Patient & Restricted Trust Funds	14	6	72	160
Properties Intended for Sale		210	205	210
Total current assets		9,474	14,245	13,767
Non current assets				
Investments	6	-	2	2
Fixed Assets	7	29,085	24,693	25,722
Total non current assets		29,085	24,695	25,724
Total assets		38,559	38,940	39,491
LIABILITIES				
Current Liabilities				
Bank overdraft (secured)	8	-	-	-
Payables and accruals	9	7,533	9,272	9,261
Employee entitlements	10	2,712	2,879	2,666
Current Portion of term loans	11	11,195	11,195	11,404
Patient & Restricted Trust Funds	14	6	72	160
Total current liabilities		21,446	23,418	23,491
Non Current Liabilities				
Employee entitlements	10	2,233	2,309	2,120
Term loans	11	-	-	-
Total non current liabilities		2,233	2,309	2,120
Total liabilities		23,679	25,727	25,611
NET ASSETS		14,880	13,213	13,880

For and on behalf of the Board



Chairman
21 October 2005

Deputy Chair
21 October 2005

The accompanying statement of accounting policies on pages 15 to 17, and notes on pages 22 to 31 form part of these financial statements.

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Budget June 2005 $000	Actual June 2005 $000	Actual June 2004 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MoH, patients and other revenue		83,660	83,271	75,723
Interest received		157	576	264
		83,817	83,847	75,987
Cash was disbursed to:				
Payments to suppliers		48,150	46,035	40,145
Payments to employees		33,912	33,094	31,387
Interest paid		870	560	750
GST (net)		108	206	(261)
Capital charge		2,746	2,256	352
		85,786	82,151	72,373
Net cash (outflow) / inflow from operating activities	12	(1,969)	1,696	3,614
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of fixed assets		-	-	14
		-	-	14
Cash was applied to:				
Purchase of fixed assets		6,050	1,754	1,695
		6,050	1,754	1,695
Net cash (outflow) / inflow from investing activities		(6,050)	(1,754)	(1,681)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds of capital injection		3,680	1,000	2,078
Proceeds from debt financing		-	11,195	11,195
		3,680	12,195	13,273
Cash was applied to:				
Repayment of loans		209	11,327	11,664
		209	11,327	11,664
Net cash (outflow) / Inflow from financing activities		3,471	868	1,609
Net increase in cash held		(4,548)	810	3,542
Add opening cash		6,262	6,262	2,720
CLOSING CASH BALANCE		1,714	7,072	6,262
Made up of:				
Cash & Investment		1,714	7,072	6,262
Bank overdraft		-	-	-
CLOSING CASH BALANCE		1,714	7,072	6,262

The accompanying statement of accounting policies on pages 15 to 17, and notes on pages 22 to 31 form part of these financial statements

STATEMENT OF CONTINGENT LIABILITES

AS AT 30 JUNE 2005

	June 2005 $000	June 2004 $000
Legal proceedings and disputes by third parties	-	50
Personal grievances	150	125

The West Coast DHB is currently involved in legal proceedings under the NZ Public Health and Disability Act 2000. The WCDHB denies any liability and is defending the claims.

STATEMENT OF COMMITMENTS

AS AT 30 JUNE 2005

	June 2005 $000	June 2004 $000
Capital commitments approved and contracted	2,299	150
Non-cancellable operating lease commitments		
Less than one year	536	344
One to two years	537	131
Two to five years	1,610	72
	4,982	697

Other non-cancellable contracts

The Board has entered into non-cancellable contracts for the provision of services. Details of the commitments under these contracts are as follows:

	June 2005 $000	June 2004 $000
Not later than one year	3,094	2,038
Later than one year and not later than two years	2,614	49
Later than two years and not later than five years	2,572	4
	8,280	2,091
Total commitments	13,262	2,788

Note 1 : Operating deficit

	June 2005 $000	June 2004 $000
After charging:		
Remuneration of auditor - Audit Fees	53	51
- Other Services	8	-
Depreciation - Buildings	404	402
- Plant and equipment	2,172	2,232
- Motor vehicles	39	54
Total depreciation charge for year	2,615	2,688
Write down revaluation of fixed assets	-	3
Board Members' remuneration	164	169
Interest expense - term loans (including bank overdraft)	744	645
- finance leases	5	14
Donations	1	1
Rental and Operating lease costs	379	326
Bad debts written off	23	23
Changes in provision for bad debts	5	28
Loss on disposal of assets	55	66
After crediting:		
Interest income	584	266
Donations and bequests	25	5
Gain on sale of assets	-	15

Note 2 : Tax expense

Pursuant to the NZ Health and Disability Act 2000, the WCDHB is a public authority and exempt from income tax.

Note 3 : PUBLIC EQUITY

3(a) ***General Funds***

	June 2005 $000	June 2004 $000
Opening Balance	43,147	41,069
Equity received during the year	1,000	2,078
Crown Equity as at 30 June	44,147	43,147

3(b) ***Retained earnings***

	June 2005 $000	June 2004 $000
Retained earnings as at 1 July	(37,853)	(37,417)
Operating deficit	(1,676)	(438)
Transfer to Trust Funds (note 3 (c))	-	-
Transfer from Trust Funds (note 3 (c))	2	2
Retained earnings as at 30 June	(39,527)	(37,853)

3(c) ***Trust funds***

Trust funds are funds donated or bequested for a specific purpose.

The use of these funds must comply with the specific terms of the sources from which the funds were derived.

Revenue and expenditure in respect of these Trusts is recognised in the Statement of Financial Performance. An amount equal to the expenditure is transferred from the Trust Fund component of Equity to Retained Earnings. An amount equivalent to the revenue is transferred from Retained Earnings to Trust Funds.

	June 2005 $000	June 2004 $000
Opening Balance 1 July	43	45
Transfer from retained earnings in respect of:		
Funds received	-	-
Interest received	-	-
Transfer to retained earnings: in respect of funds spent	(2)	(2)
Trust funds at 30 June	41	43

3(d) ***Asset Revaluation Reserve***

	June 2005 $000	June 2004 $000
Opening Balance 1 July	8,543	8,543
Increase in Asset Revaluation Reserve	9	-
Asset Revaluation Reserve as at 30 June	8,552	8,543

Note 4 : Receivables and prepayments

	June 2005 $000	June 2004 $000
Trade debtors	1,055	4,793
Provision for doubtful debts	(61)	(56)
	994	4,737
Accrued income	5,020	1,527
Prepayments	285	293
Total receivables and prepayments	6,299	6,557

Note 5 : Inventories

	June 2005 $000	June 2004 $000
Pharmaceuticals	157	142
Surgical and medical supplies	336	336
Other supplies	104	100
Total inventories	597	578

No inventories are pledged as security for liabilities nor are any inventories subject to retention of title clauses.

Note 6 : Investments

	June 2005 $000	June 2004 $000
Other investments	2	2
Total investments	2	2

WCDHB has a 4% share in SISSAL (South Island Shared Services Limited) (2004: 4%)

Note 7 : Fixed assets

	June 2005 $000	June 2004 $000
Freehold land - at valuation	1,576	1,576
Freehold buildings - at cost and valuation	9,123	9,115
Accumulated depreciation	(861)	(463)
Freehold buildings - net book value	8,262	8,652
Buildings fit out - at cost and valuation	11,271	11,207
Accumulated depreciation	(2,093)	(1,040)
Buildings fit out - net book value	9,178	10,167
Equipment - at cost	11,872	11,251
Accumulated depreciation	(7,050)	(6,527)
Equipment - net book value	4,822	4,724
Motor Vehicles - at cost	639	762
Accumulated depreciation	(584)	(614)
Motor Vehicles - net book value	55	148
Computers - at cost	3,862	3,796
Accumulated depreciation	(3,436)	(3,341)
Computers - net book value	426	455
Capital work in progress	374	-
	374	-
Total fixed assets at cost and valuation	38,717	37,707
Accumulated depreciation	(14,024)	(11,985)
Net book value of fixed assets	24,693	25,722

Land and Buildings
Freehold land, buildings and fit out were revalued under FRS3, as at 30 June 2003, by Coast Valuations (Registered Valuers). They are stated at net current value. The resulting increase in land, buildings and fit out has been recognised in equity in an Asset Revaluation Reserve (refer to note 3(d)).

Restrictions
The West Coast District Health Board does not have full title to Crown land it occupies but transfer is arranged when land is sold. Some of the DHBs land is subject to Waitangi Tribunal claims. The disposals of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to West Coast District Health Board are subject to a memorial in terms of the Treaty of Waitangi Act 1975 [as amended by Treaty of Waitangi (State Enterprises) Act 1988]. The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

Note 8 : Bank overdraft

The bank overdraft facility available as at 30 June 2005 totalled $3,690,000 and the interest rate on the overdraft was 7.245% per annum.

Note 9 : Payables and accruals

	June 2005 $000	June 2004 $000
Trade creditors and accruals	6,751	5,887
Revenue in advance	563	51
Capital charges due to the Crown	246	1,554
GST payable	271	477
Payroll accruals	1,441	1,292
Total payable and accruals	9,272	9,261

Note 10 : Employee entitlements

	June 2005 $000	June 2004 $000
Retiring gratuities	2,209	2,205
Long service leave	287	258
Annual leave	2,146	2,162
Nurses leave (shift)	149	138
Medical education and sabbatical leave	397	17
Others	-	6
	5,188	4,786
Made up of:		
Current		
Retiring gratuities	298	330
Long service leave	21	13
Annual leave	2,146	2,162
Nurses leave (shift)	149	138
Medical education and sabbatical leave	265	17
Others	-	6
	2,879	2,666
Non-current	2,309	2,120

Note 11 : Term loans

	June 2005 $000	June 2004 $000
Crown Health Finance Agency (CHFA)	11,195	11,195
BNZ CT Scanner	-	105
Finance lease-Toyota Finance	-	104
Total	11,195	11,404
Less current portion	11,195	11,404
Non current portion	-	-
Interest Rate Summary:		
Crown Health Finance Agency	6.72%	6.15%
BNZ CT Scanner		8.64%
Finance lease-Toyota Finance		8.06-8.95%
Repayable as follows:		
Within one year	11,195	11,404
	11,195	11,404

Analysis of Finance Lease Liabilities

Payable no later than one year	-	108
	-	108
Future finance charges	-	(4)
Recognised as a liability	-	104
Representing lease liabilities		
Current	0	108

The Crown Health Financing Agency (CHFA) loans are secured by a negative pledge. This restricts the DHB's actions in the following areas without the CHFA's written consent.

(a) Security Interest: Create any security interest over its assets except in certain defined circumstances.
OR

(b) Loans and Guarantees: Lend money to another person (except in the normal course of business), or give a guarantee.
OR

(c) Change of Business: Make or threaten to make a substantial change in the nature or scope of its business as presently conducted.
OR

(d) Disposals: Dispose of any assets except in the normal course of business or disposals for full value.

(e) Provide Services: Other than for proper value and on reasonable commercial terms.

Note 12 : Reconciliation of net surplus/(deficit) after taxation with net cash flow from operating activities

	June 2005 $000	June 2004 $000
Net deficit	(1,676)	(438)
Add back non-cash items:		
Depreciation	2,615	2,688
Write down revaluation of assets	-	3
Total non-cash items	2,615	2,691
Adjust for items not classified as operating activities:		
Net loss on disposal of fixed assets	55	28
Non operating activities-net	55	28
Add/(less) movements in working capital items		
Decrease/(increase) in receivable and prepayments	259	(2,297)
(Increase)/decrease in inventories	(19)	24
Increase in employee provisions	401	404
Increase in payables and accruals	61	3,202
Working capital movement - net	702	1,333
Net cash inflow from operating activities	1,696	3,614

Note 13: 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, accounts receivable, trade creditors 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. Its policies do not allow any transactions which are speculative in nature to be entered into.

Interest Rate Risk
Interest rate risk is the risk that the value of financial instruments will fluctuate due to changes in market interest rates.

The West Coast DHB has entered into an interest rate swap agreement, so as to effectively fix the refinancing interest rate of $4.3M of its $11.195M CHFA loan for the 5 years commencing 30 June 2004 at an effective interest rate of 6.79% per annum. The swap has a nominal rate of 6.59%, however West Coast DHB is charged a margin of 0.2% over the government bond rate on our CHFA loan.

At 30 June 2005, the valuation of this financial instrument was $14,157 in the bank's favour. This cost has not been recorded in the Financial Statements.

Currency Risk
Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates. The West Coast DHB has no exposure to currency risk.

Credit Risk
Credit risk is the risk that a third party will default on its obligation to the group causing the group to incur a loss.

Financial instruments which potentially subject the organisation to risk consist principally of cash, short-term investments and trade receivables.

The Board places its cash and short-term investments with high credit quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health which comprises 87% (2004:81%) of the debtors of the West Coast District Health Board. However, the Ministry of Health is a high credit quality entity, being the Government funder of health and disability support services for the West Coast region and the Board considers the risk arising from this concentration of credit to be very low.

Fair Values
The fair value of other financial instruments is approximated by the carrying amount disclosed in the Statement of Financial Position.

Note 14: Patient funds and restricted trust funds

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

	June 2005 $000	June 2004 $000
Opening balance patients deposits	154	163
Monies received	29	42
Interest earned	7	7
Payments made	(124)	(58)
Closing Balance	66	154

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

	June 2005 $000	June 2004 $000
Opening balance restricted trust funds	6	5
Monies Received	-	-
Interest earned	-	1
Payments made	-	-
Closing Balance	6	6
Total Patient Funds and Restricted Trust Funds	72	160

Note 15: Post balance date events

The Board is not aware of the existence of any post balance date events.

Note 16: Capital Charge

The DHB pays a capital charge monthly to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2005 was 11% (2004: 11%).

Note 17: Related parties transactions

The West Coast District Health Board is a Crown entity. The Government significantly influences the role of the organisation.

Related party transactions and balances

(a) Funding

The West Coast DHB received $76,264,000 from the Ministry of Health to fund the provision of health services to the West Coast area in the 12 months ended 30 June 2005 (2004: $75,600,000).

The amount due at year end was $5,288,180 (2004: $5,091,802).

(b) Key management and directors

Some of the members of the West Coast District Health Board are also employed as staff of the Board.

Malcolm Stuart (employed as Head of Department, Anaesthesia).
Robyne Bryant (employed as a Midwife on a casual basis).
Carol Atmore (employed as a General Practitioner and GP Liaison Officer).
Remuneration for these activities is consistent with expertise involved.

Board member Julie Kilkelly is a trustee of the West Coast PHO Board. The West Coat DHB provides funding to and receives funding from, the West Coast PHO for GP services. For the year ended 30 June 2005, the West Coast DHB made payments to the West Coast PHO totalling $2,663,043 (2004: $2,557,087 and received funding of $780,557 (2004: $615,458).

Julie Kilkelly is a director of Olsen's Pharmacy (2002) Ltd. The West Coast DHB has agreements with community pharmacies for the provision of pharmaceuticals and related services to the community. Payments to Olsen's Pharmacy to 30 June 2005 amounted to 21% (2004: 23%) of the DHB Funders total pharmaceutical expenditure.

Board member Robyne Bryant is a Trustee of the Board of Coast Care Trust. The West Coast DHB has a contract with Coast Care Trust to provide community activity programs. Payments to Coast Care Trust to 30 June 2005 amounted to 100% (2004: 100%) of the DHB Funders total expenditure on community activity programmes.

June Robinson (West Coast DHB Board member to 6 December 2004) is a Board member of Rata Te Awhina Trust. The West Coast DHB has contracts with Rata Te Awhina Trust for the provision of Maori Health Services on the West Coast. Payments to Rata Te Awhina Trust to 6 December 2004 amounted to 100% (2004, 12 months to 30 June: 59%) of the DHB Funders total expenditure on Maori targeted health services.

(c) Other related parties	**Year ended 30 June 2005**	**Year ended 30 June 2004**
	$000	**$000**
South Island Shared Services Limited (SISSAL)	163	204

Note 18 : FINANCIAL PERFORMANCE INDICATORS

Indicator	Year ended 30 June 2005	Year ended 30 June 2004
Earnings / Net funds employed - %	-12.7%	-3.2%
Debt to debt plus equity - %	45.9%	45.1%
Working capital / Revenue - %	-11.2%	-12.4%
Revenue / Fixed assets - times	3.37	3.04
Interest cover – times (Earnings before interest and depreciation/interest exp)	2.25	4.41
Earnings / Revenue - %	-2.0%	-0.6%
Revenue / FTE's (as at 30 June 2005) - $	139,788	135,394

OTHER FINANCIAL DISCLOSURES

REMUNERATION

Remuneration paid to Board and Advisory Committee members for the year ended 30 June 2005.

	Board	Advisory Committee	Total
G Coster (Chairman)	30,000	1,250	31,250
C Robertson (Deputy Chair)	18,750	2,063	20,813
R Bryant	15,000	2,000	17,000
J Kilkelly	15,000	938	15,938
M Shahadat	15,000	1,438	16,438
M Stuart	15,000	-	15,000
J Vaile	15,000	1,875	16,875
B Wilkinson (from 6/12/04)	8,542	813	9,355
C Atmore (from 6/12/04)	8,542	250	8,792
G Baldick (from 6/12/04 to 28/2/05 From March 2005-June 2005 Acting CEO)	3,542	-	3,542
M Moore (to 5/12/04)	6,458	500	6,958
J Robinson (to 6/12/04)	6,500	250	6,750
T Sinclair (to 5/12/04)	6,458	1,000	7,458
E Stratford (DSSAC)		1,500	1,500
L Mason (CPHAC)		750	750
B Greer (CPHAC)		1,250	1,250
K Cannan (HAC)		1,000	1,000
M Moir (HAC)		1,250	1,250
R Wallace (HAC)		500	500
B Beckford (CPHAC, HAC)		3,000	3,000
G Hammond (DSSAC)		1,500	1,500
M Frankpitt (DSSAC)		1,500	1,500
E Rock (MHAC)		500	500
D Lewis (DSSAC)		750	750
	163,792	25,877	189,669

DSSAC	Disability Support Services Advisory Committee
CPHAC	Community Public Health Advisory Committee
HAC	Hospital Advisory Committee
MHAC	Mental Health Advisory Committee

INSURANCE

Members and officers liability insurance and letters of indemnity have been arranged which cover the actions of Members and Officers of the West Coast District Health Board.

REMUNERATION OF EMPLOYEES EARNINGS MORE THAN $100,000 PER ANNUM

Salary Range ($)	Number of Employees
100,001 - 110,000	4
110,001 - 120,000	2
120,001 - 130,000	4
130,001 - 140,000	2
140,001 - 150,000	3
180,001 - 190,000	1
200,001 - 210,000	2
210,001 - 220,000	1
220,001 - 230,000	1
240,001 - 250,000	2
260,001 - 270,000	1
300,001 - 310,000	1
520,001 - 530,000	1

Twenty five employees received total remuneration of greater than $100,000. The figure stated includes payment for additional duties and any lump sum payments during the year including payment of accrued leave.

The Chief Executive's remuneration (resigned March 2005) is in the $200,001 - $210,000 band.

Of the twenty five employees shown, nineteen are or were medical employees and six were not medical employees.

If the remuneration of part time employees or employees who had not completed a full 12 months of employment was grossed up to a full time equivalent (FTE) basis the total number of employees with FTE salaries of $100,000 or more would be thirty one, compared with the actual number of employees of twenty five. All additional employees are medical staff.

TERMINATION OF EMPLOYMENT PAYMENTS

Section 42(3) (f) of the New Zealand Public Health and Disability Act 2000 requires disclosure of payments arising from the termination of an employees service.

During the year ended 30 June 2005 the Board made payments totalling $270,694 to nine former employees. The amounts paid were $9,739, $20,000, $26,844, $31,166, $32,508, $33,212, $35,363, $40,931, $40,931.

BOARD MEMBERS' INTEREST

The following items were entered in the interests register for the Board members as at 30 June 2005. (Refer to table of Page 7).

There have been no financial transactions during the year involving the Board requiring the declaration of an interest.

The Board has not extended any loans to Board members.

No notices have been received from Board members requesting the use of Board information received in their capacity as Board members, which would otherwise not have been available to them.

AUDIT, RISK & FINANCE COMMITTEE

Board Members: Mohammed Shahadat (Chairman), Christine Robertson and Robyn Bryant.

The role of the Audit, Risk and Finance Sub Committee is to assist the Board in discharging its responsibilities by ensuring compliance procedures are in place for all statutory requirements relating to the operation of the Board, in particular with regard to the safety, service, quality and regulation, privacy of patients, financial reporting and risk management.

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE FOR THE 12 MONTHS ENDING 30 JUNE 2005

This report details our performance to our service objectives and performance targets, as stated in our 2005-08 Statement of Intent, the formal accountability document that set out the DHB's plans and performance targets at the start of the financial year.

NATURE AND SCOPE OF ACTIVITIES

The West Coast DHB was established under the New Zealand Public Health and Disability Act 2000, and is the principal funder and provider of health and disability services to the 30,303[1] people living in the West Coast district.

With its small resident population and large geographic area (8.5% of New Zealand's land area) the West Coast DHB faces a number of challenges not faced by other DHBs. Our geography and rurality create significant diseconomies of scale in the delivery of services provided by the DHB. Notwithstanding, we both fund and provide a broad range of health services to our population.

The West Coast DHB periodically conducts needs analyses, surveys and collects other data in order to ascertain the health needs and priorities of the West Coast population.

Strategies aimed at meeting these needs and priorities form the basis of the West Coast DHB's Strategic Plan and are operationalised through their inclusion in the DHB's District Annual Plan (outlining our objectives for the next 1 to 3 years) and the DHB's Statement of Intent, which states our specific service objectives and performance targets for the current financial year.

SERVICE PERFORMANCE

Objectives and performance targets have been divided up according to the functional areas that they relate to.

Objectives and Performance Targets – DHB Governance & Management

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

The governance role of the West Coast DHB is also focussed on monitoring the delivery and performance of services, by the DHB and other parties engaged by the DHB in its strategies to improve health status.

The role also encompasses activities that facilitate co-operative and collaborative arrangements with other organisations in the health and disability sector.

Outputs reflecting the success in achieving these objectives are referred to as "DHB Governance Outputs".

[1] 2001 NZ Census

DHB GOVERNANCE, MANAGEMENT & PERFORMANCE OUTPUTS

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
Priority - Managing Resources within Available Funding		
Although our plan indicates a significant financial deficit, we are committed to investigating all potential avenues for improved efficiency, subject to our stated health priorities and clinical and political constraints.	Within the 2004-05 Financial Year at least two reviews will have occurred within aspects of WCDHB's operations, with a view to identifying the potential to improve efficiency.	**Achieved** West Coast DHB has made considerable savings in the areas of vehicle fleet management, insurance and the procurement of office equipment and computer systems. • We have engaged in a multifaceted review of our financial performance, conducted by the Crown Health Financing Agency and have undertaken an internal review of Nursing structures, and their efficiency and effectiveness. • We have also undertaken a detailed benchmarking exercise with Wairarapa and Tairawhiti DHB in order to identify any opportunities for savings in clinical supply costs. We have also been working on a multifaceted collaboration project, exploring opportunities for improved efficiency and clinical effectiveness from closer collaboration with Canterbury DHB.
The West Coast DHB is committed to ensuring that actual financial performance is in line with the approved Annual Plan for the Funder, Provider and Governance Functions of the DHB.	All sections of the DHB to achieve or improve on their planned results for the 2004-05 Financial Year.	**Achieved** The financial section of this report shows an end of year result that is significantly better than budget.
Priority - Maori Health		
Implementation of the West Coast DHB's Maori Health Plan (available on website)	Full narrative report on implementation to identify whether tasks have been achieved, partially achieved or not achieved	**Partially Achieved** Recently the GM Maori Health sent a performance monitoring return to the MOH Maori Health Directorate regarding progress to date of the Maori health plan. In addition the GM Maori Health has reported progress to date to both the Community and Public Health Advisory Committee and the Hospital Advisory Committee. This information in turn is reported back to the WCDHB Board. There has been extensive progress made measured against the objectives within the plan. However not every objective within the plan is achieved.
Renegotiation of services contracts will see an increased level of service provided by Maori Health Providers from July 2004. There will be a particular increase in service provided in areas with the greatest Maori populations and highest levels of socio-economic deprivation.	Before the end of the 2004-05 Financial Year, WCDHB contracts with Maori Health Providers will incorporate funding of equal levels of service in the Buller, Grey and Westland Districts, with a further requirement to prioritise according to need.	**Partly Achieved** There has been agreement with the Maori health service provider, Rata Te Awhina Trust, that the service contract will be amended in these ways, but finalisation of the contract has been delayed pending Ministry of Health approval of the draft service specification for the contract.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
West Coast DHB will implement a Maori Health Needs Analysis process that incorporates qualitative measures of Whanau Ora.	Maori Health Needs Analysis published before June 2005	**Not Achieved** West Coast DHB intended to implement this needs analysis in collaboration with other South Island DHBs, but this proved impossible once other DHBs withdrew from the project. West Coast DHB is now working with Community and Public Health to undertake a West Coast specific project, and this will be completed in 2005/06.
West Coast DHB will have in place a Kaiawhina to facilitate meeting cultural needs of Maori clients.	Kaiawhina to be employed before September 2004	**Achieved** The WCDHB has employed a Kaiawhina since July 2004. The Kaiawhina provides assistance and support to in-patients and out-patients who are accessing WCDHB health services within Grey Base Hospital. This includes assistance with the complaints procedure and advocacy support.
Development of specific Maori Workforce Plan	Maori Workforce Plan completed by December 2004	**Achieved** The HR Manager and GM Maori Health have collaboratively produced a WCDHB Maori Workforce Development Plan 2003-2009. The main focus of this plan is to increase the number, and improve the skills of the Maori Health and Disability workforce. A Maori Workforce Development Plan for Te Waipounamu (South Island) has been developed by Te Herenga Hauora (South Island DHB Maori Managers Network). The intention of this plan is that it should sit alongside Raranga Tupuake (National Maori Workforce Development Plan). This plan will provide a regional focus on the development of Maori health and disability workers across the South Island.
Review of care pathways for Maori	Care pathways review completed January 2005	**Partially achieved** We are currently reviewing pathways of care for Maori. The introduction of Tikanga Recommended Best Practice will establish a pathway, and is due to be completed. A survey of Maori accessing services to determine barriers is currently being developed.
Tikanga Best Practice training to mainstream staff	20% of clinical staff through Tikanga training by 30 June 2005	**Partially achieved** A important initiative implemented is Te Pikorua. To date three full day training programmes have been provided to staff. Te Pikorua consists of three workshops; (1) Traditional concepts of Te Ao Maori (the Maori world); (2) Haki Nohi – Clinical application of traditional Maori concepts; (3) Tikanga Best Practice. We have funding set aside to provide Te Pikorua training to staff for the next year. In addition, we are providing Treaty of Waitangi training for staff. Numbers attending these training programmes are always very high and evaluation forms filled out by staff suggest a high level of satisfaction from these trainings. We also have a half-hour session within the mandatory Orientation programme for all new WCDHB staff where they are provided with a brief introduction to Maori health.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
Priority - Public Health		
Intersectoral collaboration with local and central government agencies aimed at improving health outcomes.	In the 2004/05 year WCDHB will have collaborated with local government on the Coast in at least the areas of fluoridation and transport, and with central government agencies in at least the areas of housing and wellbeing of older adults.	**Achieved** WCDHB has worked closely with local Government on fluoridation of drinking water supplies and on transport, and with central government on a housing project (improving housing insulation and on issues for older adults (arising out of the WISE project). WCDHB has initiated a new inter-sectoral forum on the West Coast, which will be meeting through 2005/06.
Collaboration with Community and Public Health and other agencies active in the Inangahua community to improve the health outcomes of people in the Inangahua district using "healthy communities" techniques.	WCDHB signatory to Health Inangahua Charter achieved by December 2004	**Achieved** West Coast DHB has become a signatory to the Healthy Inangahua Charter
WCDHB to act in a leadership role in public health on the West Coast	West Coast DHB will have implemented in the 2004/05 year a public health initiative with participation by at least 20% of its own workforce (WCDHB is the largest employer on the West Coast) around healthy eating and physical activity. 	**Achieved** Spring into Action is a physical activity initiative designed by the West Coast DHB and our colleagues at our public health unit, Community and Public Health. It is a 6-week promotion designed to encourage physical activity every day of the week. Participants form teams and are scored according to how much physical activity they do. The first Spring into Action Competition was an in-house pilot conducted in October-November 2004. 182 DHB staff members took part. Feedback from the teams was very positive and the decision was made to roll out Spring into Action Coast-wide, inviting anyone to register a team. The second competition took place in February-March 2005, and included an individual category for super-active people. Over 450 participants registered from workplaces all over the Coast, including schools, councils, supermarkets and NGOs. Formal evaluation was not done, but voluntary feedback included reports of people quitting smoking and plenty of enthusiasm for "next time".
Work with Canterbury DHB's Community and Public Health Department to extend their inequalities training to the West Coast DHB employees	All Board and Advisory Committee members, Senior Managers and a representative of each department attending training and help network development before June 2005	**Partially Achieved** Senior managers have all attended inequalities training, but this will not be implemented for Board and Advisory Committee members and other operating and administrative staff until the 2005/06 year.
Priority – Primary Health Care		
Publication of West Coast Primary Health Strategy setting out a comprehensive range of	Strategy published by April 2005	**Partially Achieved** A consultation draft of the West Coast Primary Care Plan was distributed in June 2005, with a view to the plan being finalised early in the

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
plans including recruitment and retention of workforce, future patterns of primary care, former SAMO areas, control of expenditure on referred services and ownership of service providers.		2005/06 year.
West Coast DHB will contract with the West Coast PHO for delivery of health promotion services, services to improve access, and free sexual health services for people under the age of 22.	Contract in place before January 2005	**Achieved** This contract was finalised in December 2004. Under these contract arrangements, funding has been provided to West Coast PHO practitioners to provide: • Health promotion activities aimed at meeting the Primary Health Care Strategy: population health objectives for promoting good health and preventing or reducing injury, disease or disability. • Services to improve access including funding to facilitate access to general practice and pharmaceutical services for correction service participants at reduced costs (and free in some instances) • Services to improve access including funding to significantly reduce the cost of general practice services for smokers seeking to quit smoking. • Free contraceptive and primary sexual health services aimed at reducing ill-health and unwanted pregnancy for people under the age of 22.
West Coast PHO will have developed a quality plan and a Maori Health Plan to the satisfaction of WCDHB.	Satisfactory plans developed by April 2005	**Not Achieved** Satisfactory plans have not yet been received from the West Coast PHO, but are expected in September 2005.
Introduction of a full range of electronic communications mechanisms and protocols between primary and secondary care sites (see the WCDHB District Annual Plan for more detail).	All Coast Health care sites connected by May 2005 and offered to all other primary care providers before July 2005	**Partially Achieved** Implementation of Project PRISM was slightly delayed, but otherwise proceeded on track. Most Coast Health Care sites were connected before the end of the 2004/05 year, but the final site not connected until August 2005. The offer to other primary care providers will be made in 2005/06.
Adequate service availability available throughout the West Coast at all times	Compliance with the Ministry' of Health's service coverage standard for non-urgent assessment and treatment (95% to receive services within 3 days and 100% within 7 days for the West Coast as a whole)	**Partially Achieved** There have been times due to the ongoing shortage of GPs on the West Coast when temporary limits have been placed on access to non urgent assessment and treatment by GPs. Nurse led triage, assessment and treatment has always been available to members of the public, backed up by GPs.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
Priority - Secondary Health Care		
All WCDHB secondary care premises will be certified.	To be achieved before the end of 2004	**Achieved** Achieved one year certification. Verification Auditors commended progress achieved to date. Coast Health Care team regularly meet to monitor certification of all secondary care premises.
Credentialling of all WCDHB Senior Clinical staff .	To be completed before December 2005.	**Achieved** As at 30 June 2005 the outstanding clinicians to be credentialled are one physician and two general surgeons.
Improved liaison between general practice and WCDHB secondary care services will see improved health outcomes for patients.	Survey of West Coast general practitioners in 2005 shows 75% or more believe liaison with secondary care services has improved.	**Partially Achieved** The appointment of the GP Liaison Officer continues to provide improvements in relationships between GPS and secondary care services. A final survey is still to occur.
WCDHB will continue to progressively implement all recommendations of the review of general surgery conducted by the Royal Australasian College of Surgeons.	Follow up review by RACS indicates all recommendations being satisfactorily implemented or progressed.	**Partially Achieved** The Surgeon required to fulfil the recommendations is no longer employed by the West Coast DHB The recommendations within the RACS review relating to West Coast DHB surgical services more generally have been progressively implemented, but RACS has not conducted a follow up review.
Priority - Mental Health		
Development of a new Dementia Unit to be built on the Grey Base Hospital site, and Seaview Hospital to be completely closed.	Construction of new Unit to have begun before the end of the 2004-05 year.	**Not Achieved** A business case for the construction of a new Dementia Unit, co-located with AT&R services was taken to the Ministry of Health, and funding for the capital costs approved. However, this approval was conditional on other potential providers being given a second opportunity to be considered as a potential provider of the service. Following completion of a tendering process, the DHB provider arm was confirmed as the service provider. Planning for the future configuration of the Grey Base Hospital further delayed the commencement of the project, now expected to commence once Ministry of Health confirmation is received of a modified business case, by the end of 2005.
A range of innovative approaches to mental health services for people with mild to moderate mental illness will be introduced in primary care.	Contract for these services agreed with PHO before March 2005.	**Partially Achieved** Agreement on a contract for these services was very substantially concluded before the end of 2004/05, following approval by the Ministry of Health but the contract had not been finalised.

<table>
<tr><th>Output</th><th>Performance Target to 30/6/05</th><th>Actual Performance to 30/6/05</th></tr>
<tr><td>Improved access to a range of more specialised mental health and alcohol and other drug services will progressively result from some services in other parts of the South Island being made available to all South Island DHBs during the course of 2004/05.</td><td>Utilisation of specialised regional services in 2004-05 year demonstrates improved access to these services.</td><td>Achieved
Access to specialised MH and AOD services, primarily based in Canterbury, is now assured for West Coast residents. The number of people accessing these services is small so it is difficult to generalise re improving access, but the associated qualitative controls re ease of accessing the services demonstrates no ongoing issue for this DHB, at this point.</td></tr>
<tr><td>Funding previously used for the Hanmer Institute will be used to fund a new mobile service that will be provided on the West Coast.</td><td>Contracts for service in place before March 2005</td><td>Not Achieved
Difficulties have arisen re the implementation of the original proposal re a mobile service and the proposal is being reworked. Funding remains available within the DHB for this purpose.</td></tr>
<tr><td>Better access to primary care services for people with severe mental illness</td><td>95% of clients of the MHS are linked to an appropriate primary care provider by June 2005</td><td>Partially Achieved
Data shows that of the 189 clients with severe and enduring mental illness, 153 are currently linked with a GP (81%). The roll out of GP Link, a programme aimed at facilitating access to GP services through better linkages between WINZ, specialist MH services and primary practitioners means more clients are being linked to GPs and it is hoped that we achieve our 95% goal in the next year. The consequence of this will be improved health status for people with serious mental illness.</td></tr>
<tr><td>Appropriate access to mental health services for people with severe mental illness</td><td>The following targets are met for the 2004-05 year:

Targets for average proportion of West Coast domiciled people seen per month
<table>
<tr><th></th><th>Maori</th><th>Other</th><th>Total</th></tr>
<tr><td>Child & Youth</td><td>1.3%</td><td>1.3%</td><td>1.3%</td></tr>
<tr><td>Adult</td><td>2.32%</td><td>2.25%</td><td>2.26%</td></tr>
</table></td><td>Partially Achieved

Mar-05
<table>
<tr><th>ACTUAL</th><th>Maori</th><th>Other</th><th>Total</th></tr>
<tr><td>Child and Youth</td><td>0.66%</td><td>0.86%</td><td>0.83%</td></tr>
<tr><td>Adult</td><td>1.97%</td><td>1.75%</td><td>1.77%</td></tr>
<tr><td>Older people</td><td>0.83%</td><td>1.02%</td><td>1.02%</td></tr>
</table>
The West Coast population accesses mental health services at a higher rate than any other DHB. Rates of actual access to services often reflect sometimes small population numbers (and therefore fluctuating numbers), no or minimal waiting times and sometimes availability of staff within a particular service.</td></tr>
<tr><td>Rehabilitation support services review implemented</td><td>Reconfiguration complete before July 2005</td><td>Partially Completed
The rehabilitation review is now firmly in the implementation phase having received recent approval in principle from Community Housing for funding. Design and costs are currently being finalised between Community Housing and PACT, the lead NGO contracted to provide the residential service. Completion time is estimated to be 18 months.</td></tr>
</table>

<table>
<tr><th>Output</th><th>Performance Target to 30/6/05</th><th>Actual Performance to 30/6/05</th></tr>
<tr><td colspan="3">Priority - Oral Health</td></tr>
<tr><td>WCDHB will continue to work towards fluoridation of drinking water supplies in conjunction with territorial local authorities, Community and Public Health and oral health professionals.</td><td>At least one of the three Territorial Local Authorities on the West Coast to have made the decision to fluoridate water supply before July 2005</td><td>Partially Achieved
In September 2004, the West Coast District Health Board endorsed fluoridation as a safe and effective way to improve oral health.

In early 2005, the West Coast DHB approached 2 local authorities and began publicly supporting water fluoridation. After their respective consultation processes, the Grey District Council decided to fluoridate, but the Westland District Council declined after vocal opposition from a section of the community.

(In the face of vocal opposition, the Grey DC decided in July 2005 to put the issue to referendum).</td></tr>
<tr><td>Continued improvement to child oral health, and the development of longer term goals and strategies.</td><td>Targets for 2004-05:

Percentage Caries Free at age 5 years
<table><tr><td>Maori</td><td>Other</td></tr><tr><td>40%</td><td>49%</td></tr></table>
Mean Number of Decayed, Missing or Filled Teeth (DMFT) at Year 8 (Form 2)
<table><tr><td>Maori</td><td>Other</td></tr><tr><td>2.80</td><td>2.00</td></tr></table>
  </td><td>Partially Achieved

Percentage Caries Free at age 5 years in 2004
<table><tr><td>Maori</td><td>Other</td></tr><tr><td>35%</td><td>44%</td></tr></table>
Mean Number of Decayed, Missing or Filled Teeth (DMFT) at Year 8 (Form 2) in 2004
<table><tr><td>Maori</td><td>Other</td></tr><tr><td>2.43</td><td>1.9</td></tr></table>
Oral health indicators from the West Coast School Dental Service show an increasing prevalence of tooth decay, but a lessening severity of decay.
Oral health is a very high priority for the West Coast DHB. During 2004-05, the West Coast DHB completed, first, a Review of the School Dental Service for submission to the Ministry of Health, and then a Strategic Asset Management and Service Plan for Child and Adolescent Oral Health Services. The DHB has also been very active in promoting water fluoridation, obtained an adult-sized tooth costume for promotional activities and developed a nutrition policy for its own services.

The School Dental Service itself does everything it can to prevent dental decay in children, but its main role is in preventing any decay from worsening and spreading to other teeth. Preventative measures in the dental clinic include chairside education and the application of fissure sealants.

Ongoing activities outside of the school dental service will have the greatest impact on oral health, including the introduction of water fluoridation, reducing the consumption of high sugar drinks (especially carbonated ones) and encouraging tooth brushing in the home.</td></tr>
<tr><td colspan="3">Priority - Services for Children and Youth</td></tr>
<tr><td>A youth Health Strategy will be developed in conjunction with health</td><td>Strategy published before the end of the 2004/05 year.</td><td>Partially Achieved
The WCDHB is in the process of developing a Youth Health Strategy, which is expected to be</td></tr>
</table>

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
professionals and community stakeholders		completed by February 2006.
Both the National Immunisation Register and the School Based (Meningococcal) Vaccination Schedule will be implemented on the West Coast	Implementation before the end of 2004/05.	**Partially Achieved** The WCDHB has successfully implemented both National Immunisation Register and the School Based (Meningococcal) Vaccination Schedule However, the go live date for the use of the NIR for the birth cohort was changed by the MOH from May 2005 to 28 Nov 2005 and the NIR will not be fully implemented until that date.
All hospital-born babies on the West Coast to be born in Baby Friendly Hospitals	BFHI Accreditation of Buller and Grey Hospital facilities by September 2004.	**Partially Achieved** Accreditation received August 2005
Monitor breast-feeding data to assess need for further initiatives. Improve the quality of breast-feeding data held by General Practices and other early childhood providers.	Breast feeding status of 50% of babies documented by general practices by July 2005	**Not Achieved** There is currently no information about whether general practices are recording the breast feeding status of babies enrolled within their practice. This information is not currently provided by the West Coast PHO.
Accurate immunisation information is collected by General Practices and other early childhood providers, to enable the ongoing monitoring of immunisation levels.	Immunisation status of 80% of children documented by general practices before July 2005	**Partially Achieved** The mechanism for achieving this target is the national immunisation Register. WCDHB has successfully implemented the NIR. However, the go live date for the use of the NIR for the birth cohort was changed by the MOH from May 2005 to 28 Nov 2005 and the NIR will not be fully implemented until that date.
Child and youth health committee established to govern implementation of NIR and MeNZB programmes and to develop child and youth health strategies	Committee in place before September 2004 	**Achieved** The West Coast DHB Child and Youth Health Committee was established in September 2004. Overseen by the WCDHB planning and funding team the committee includes representation from the Hospital social work, paediatric and Child and Adolescent Mental health Teams, as well as from community health, social services and disability providers. The committee is responsible for governing the implementation of the National Immunisation Register and the MeNZB programmes and for developing child and youth health strategies.
WCDHB intends to minimise "ambulatory sensitive admission" (those that could have been prevented by services offered through primary care) to hospital for children, through	Report on the number of such admissions and proportional change from previous years by ethnicity and age. Target is for a 5% reduction in 2004-05.	**Achieved** There has been a significant reduction, greater than 5% in the 99% confidence interval, in ambulatory sensitive admission across all ethnicity and age groupings in the twelve months to 31 March 2005 (latest complete available data), compared to the twelve months to 30 June 2004. The changes are reflected in the tables below. In

<table>
<tr><th>Output</th><th>Performance Target to 30/6/05</th><th>Actual Performance to 30/6/05</th></tr>
<tr><td>improved primary care.</td><td></td><td>March 2005, the West Coast PHO began evaluating ambulatory data supplied by the West Coast DHB to see if there are specific areas of disease state management areas that General Practice might be able to assist to further reductions ambulatory sensitive admissions into the future through closer intervention.
NOTE: Volumes where raw data is five or less are too few in number to be statistically meaningful.

0 – 5 Year Olds
Rate Per 1000 Hospitalisations
<table>
<tr><td>0-5</td><td>03/04</td><td>04/05</td><td>Change</td></tr>
<tr><td>Total</td><td>76.7</td><td>67.4</td><td>- 12.1%</td></tr>
<tr><td>Maori</td><td>94.2</td><td>84.5</td><td>- 10.3%</td></tr>
<tr><td>P.I.</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Other</td><td>73.4</td><td>63.6</td><td>- 13.3%</td></tr>
</table>
Raw number of Hospitalisations
<table>
<tr><td>0-5</td><td>03/04</td><td>04/05</td><td>Change</td></tr>
<tr><td>Total</td><td>143</td><td>122</td><td>- 14.7%</td></tr>
<tr><td>Maori</td><td>31</td><td>26</td><td>- 16.1%</td></tr>
<tr><td>P.I.</td><td>0</td><td>1</td><td>-</td></tr>
<tr><td>Other</td><td>112</td><td>95</td><td>-15.2%</td></tr>
</table>
5 – 14 Year Olds
Rate Per 1000 Hospitalisations
<table>
<tr><td>5-14</td><td>03/04</td><td>04/05</td><td>Change</td></tr>
<tr><td>Total</td><td>20.5</td><td>19.7</td><td>- 3.9%</td></tr>
<tr><td>Maori</td><td>19.1</td><td>16.6</td><td>-13.1%</td></tr>
<tr><td>P.I.</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Other</td><td>20.9</td><td>20.5</td><td>- 1.9%</td></tr>
</table>
Raw number of Hospitalisations
<table>
<tr><td>5-14</td><td>03/04</td><td>04/05</td><td>Change</td></tr>
<tr><td>Total</td><td>97</td><td>91</td><td>- 6.2%</td></tr>
<tr><td>Maori</td><td>14</td><td>12</td><td>- 14.3%</td></tr>
<tr><td>P.I.</td><td>0</td><td>0</td><td>-</td></tr>
<tr><td>Other</td><td>83</td><td>79</td><td>- 4.8%</td></tr>
</table>
15 – 24 Year Olds
Rate Per 1000 Hospitalisations
<table>
<tr><td>15-24</td><td>03/04</td><td>04/05</td><td>Change</td></tr>
<tr><td>Total</td><td>17.5</td><td>14.5</td><td>- 17.1%</td></tr>
<tr><td>Maori</td><td>18.9</td><td>11.5</td><td>- 39.1%</td></tr>
<tr><td>P.I.</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Other</td><td>17.4</td><td>14.8</td><td>- 14.9%</td></tr>
</table>
Raw number of Hospitalisations
<table>
<tr><td>15-24</td><td>03/04</td><td>04/05</td><td>Change</td></tr>
<tr><td>Total</td><td>60</td><td>51</td><td>- 15.0%</td></tr>
<tr><td>Maori</td><td>9</td><td>6</td><td>- 33.3%</td></tr>
<tr><td>P.I.</td><td>0</td><td>1</td><td>-</td></tr>
<tr><td>Other</td><td>51</td><td>44</td><td>- 13.7%</td></tr>
</table>
Ambulatory sensitive hospitalisation for the twelve months to 31 March 2005 for West Coast domiciled children were not significantly different from the national rate at the 99% confidence interval across all age groups.</td></tr>
</table>

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		a. Children – Aged Under 5: Hospitalisations for children aged under 5-years were slightly lower than the national average (67.4 per 1000 for West Coast compared with the national rate of 71. per 1000). The rate for Maori children under 5 was up compared to the national average (84.5 per 1000 for West Coast Maori compared to 80.7 per 1000 national rate), but this result was also statistically within the national average band at the 99% confidence interval. The number of under 5-year old hospitalisations for Pacific Island people from the West Coast was below five, so were too few in number to draw any meaningful statistical indication from. *b. Children - Aged 5 to 14:* The rate for children aged 5 to 14 was up against the national average for the age group (19.7 per 1000 for West Coast compared to 17.8 per 1000 nationwide). The rates for West Coast domiciled Maori children were lower than the national rate, at only 15.0 hospitalisations per 1000 compared to 22.0 per 1000 across the whole country. There were no hospitalisations for any Pacific Island children aged 5-14 who are resident on the West Coast. *c. Young People – Aged 15 – 24:* The ambulatory sensitive hospitalisation rate for West Coast young people aged 15 to 24 for the twelve-month period to 31 March 2005 was also similar to, and within tolerance level to the national rate at the 99% confidence level. The rate for West Coast people in this age cohort was 14.5 per 1000 hospitalisations; up slightly from the national rate of 14.2 per 1000 hospitalisations. For Maori, the number of hospitalisations per 1000 for West Coast domiciled people was well below the national average – at 11.5 per 1000 for West Coasters compared to the national average for the group of 17.5. Like the under-5's, there were too few hospitalisations over the twelve months under review to draw any statistically meaningful data in respect of ambulatory sensitive hospitalisations for West Coast resident Pacific Island people.
Priority - Services for Older Adults		
Progressive implementation of the West Coast Improving Services for the Elderly (WISE) plan with new initiatives in all aspects of health and disability support services affecting older adults. Full details of the plan, including timeframes for delivery are available in the WCDHB District Annual Plan and on the WCDHB website.	Narrative report on implementation of the plan including commentary as to whether each of the planned tasks are achieved, partially achieved or not achieved	**Achieved** The narrative report that has been made to DSAC indicates that some actions indicated in the plan, particularly around implementation in secondary (hospital) settings have not yet been completed.

<table>
<tr><th>Output</th><th>Performance Target to 30/6/05</th><th>Actual Performance to 30/6/05</th></tr>
<tr><td>WCDHB intends to minimise “ambulatory sensitive admission” (those that could have been prevented by services offered through primary care) to hospital for older adults, through improved primary care.</td><td>Report on the number of such admissions and proportional change from previous years by ethnicity and age. Target is for a 5% reduction in 2004-05.</td><td>Achieved
There has been a significant reduction, greater than 5% in the 99% confidence interval, in ambulatory sensitive admissions across all ethnicity groupings for older adults in the twelve months to 31 March 2005 (latest complete available data), compared to the twelve months to 30 June 2004. The changes are reflected in the tables below. In March 2005, the West Coast PHO began evaluating ambulatory sensitive admission data supplied by the West Coast DHB. This adjuster is being used to determine if there are specific areas of disease state management areas in which General Practice might be able to assist, to further reduce ambulatory sensitive admission rates into the future, through closer intervention.
NOTE: Volumes where raw data is five or less are too few in number to be statistically meaningful.

Rate Per 1000 Hospitalisations
<table><tr><td>65-74</td><td>03/04</td><td>04/05</td><td>Change</td></tr><tr><td>Total</td><td>78.9</td><td>72.0</td><td>- 8.7%</td></tr><tr><td>Maori</td><td>68.2</td><td>58.9</td><td>- 13.6%</td></tr><tr><td>P.I.</td><td>-</td><td>-</td><td>-</td></tr><tr><td>Other</td><td>79.3</td><td>72.5</td><td>- 8.61%</td></tr></table>
Raw number of Hospitalisations
<table><tr><td>65-74</td><td>03/04</td><td>04/05</td><td>Change</td></tr><tr><td>Total</td><td>188</td><td>174</td><td>- 7.4%</td></tr><tr><td>Maori</td><td>6</td><td>5</td><td>-16.6%</td></tr><tr><td>P.I.</td><td>0</td><td>0</td><td>-</td></tr><tr><td>Other</td><td>182</td><td>169</td><td>- 7.1%</td></tr></table>
The overall West Coast rate for ambulatory sensitive hospitalisations over the twelve months to 31 March 2005 for older people aged 65 to 74 was not significantly greater than the national average at the 99% confidence interval. (72.0 per 1000 hospitalisations for West Coast residents compared to the national average of 63.4 per 1000 hospitalisations). For Maori, the West Coast rate was significantly lower than the national rate, at 58.9 hospitalisations per 1000 compared to the national rate of 108.6 per 1000 population. There were no hospitalisations for Pacific Island people resident on the West Coast during the twelve months to 31 March 2005.</td></tr>
<tr><td>Improved use of home based care services to reduce need for rest home and continuing care services</td><td>Establishment of reliable baseline data on use of services in home based care, rest homes and hospital level care.</td><td>Not Achieved
West Coast DHB intended to use the Ministry of Health measure and supplied data to indicate the level of West Coast DHB expenditure on services for home support against residential care, in comparison to other DHBs. To date, the Ministry of Health have been unable to draw a complete set of this information from their database, so that this measure can be tracked and monitored.

Expenditure on subsidised home-based support services (service code DSS 1010; Personal Care</td></tr>
</table>

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		and Night Relief (Personal Care), carer support (code DSS1013), and respite care (code DSS213). ***Home–based support includes:*** ***Personal care***, defined as assistance with activities of daily living that enable a person with a disability to maintain their functional ability at an optimal level. These activities include but are not limited to: • personal hygiene and grooming • toileting • dressing • transfers and mobility • feeding ***Sleepover***, defined as assistance with personal care and household tasks for an over night period of stay where there is facility for the caregiver to sleep. ***Carer Support*** is defined as support services designed to provide relief to full-time caregivers. These services are provided **inside** the home. ***Respite Care*** is defined as support services designed to provide relief to full-time caregivers **outside** the home environment **Denominator :** (**Data Source:** Ministry of Health) Expenditure on subsidised care in rest homes (service code DSS 1033), dementia units (service code DSS 1032 (M)) and long-stay hospitals (service code DSS 1006 (M)). ***Rest home care*** is defined as long term residential care for older people in a rest home environment ***Dementia unit care*** is defined as accommodation meeting the special needs of people with dementia. The unit generally accommodates up to 20 residents, are separate from accommodation provided for people who do not require specialist dementia services, are home-like, comfortable, safe and are quiet, low-stimulus areas. ***Long-stay hospital care*** is defined as long term residential care for medically frail older people in a publicly or privately owned hospital facility.
Priority - Services for People with Disabilities		
In 2003/04 the West Coast DHB developed a Disability Action Plan (appended to the District Annual Plan and also available on the WCDHB website). 2004/05 will see the progressive implementation of this plan.	Narrative report on implementation of the Plan indicating whether tasks have been achieved, partially achieved or not achieved.	**Achieved** The report that has been made to DSAC indicates that all actions in the plan have been implemented.

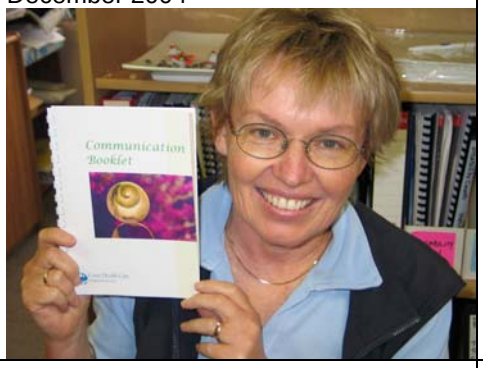
Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
Priority – Reducing the Incidence and Impact of Diabetes		
Formation of a service development group to inform a comprehensive diabetes action plan for the West Coast, incorporating both public health and chronic disease management interventions.	This plan should be published before April 2005	**Partially Achieved** The West Coast Integrated Diabetes Service Working Party was established in 2004. The group has developed a draft action plan for incorporating both public health and chronic disease management interventions. The plan has not been formally published as final (as had been anticipated in the 2004/05 SOI), as the Group decided that it needed to undertake wider consultation on the plan with providers and consumers. This consultation is currently underway. In June 2005, it was agreed that, as a way to move planning for improved diabetes services, that the Working Party merge with the Local Diabetes Team to provide more focused and ongoing momentum to the improvement of local diabetes services. The Working Party has multi-sectoral representation, including consumers, LDT members, local Maori, general practitioners, a diabetes nurse educator, a specialist physician, a local pharmacist, and WCDHB and WCPHO Board member. As a preliminary step, the group have identified several key goals for the service, including: ▪ To provide a comprehensive collaborative evidence-based service for people on the West Coast with diabetes, which empowers people to take responsibility for their own health, and be fully aware of the services available to them. ▪ The service will be effective when it allows people to receive the right care by the right person at the right place at the right time. ▪ The service will be efficient when it improves recorded parameters of diabetes management, both in terms of process and outcomes. The work of the Integrated Diabetes Service Working Party is ongoing and will be used as the basis for effective planning and moving ahead with improving diabetes services on the West Coast in 2005/06 and beyond. As signalled in our draft District Annual Plan for 2005/06, the West Coast DHB are looking to use the work of this group to inform the development of a Long-Term Diabetes Service Improvement plan, with the following goals and revised timeframes: • Development of the comprehensive draft Long-Term Diabetes Service Improvement plan by 30 June 2005 – plan sent out for consultation. Consultation completed by 30 September 2005. ▪ Finalisation of plan for implementation by 31 December 2005. Development of a comprehensive West Coast-wide diabetes database – with a view to this being in place by 30 June 2006. Through this Working Party, the WCDHB has worked closely with the West Coast PHO to advance service delivery initiatives and inter-

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		sectoral collaboration aimed at reducing the incidence and impact of diabetes and diabetes-related illnesses.
Improved detection of diabetes through screening in primary care	At present we have a fasting blood sugar result for 10% of the West Coast population over the age of 40 in the last 3 years. By the end of 2004 we aim to have a fasting blood sugar result for 50% of the population over 40, and for 50% of Maori people over the age of 30.	**Not Achieved** Data for this measure has not been collected at Primary practice level. The West Coast Integrated Diabetes Service Working Party is reviewing the national and international guidelines regarding diabetes screening. It may be most appropriately done in the context of assessing cardiovascular risk, as outlined in the New Zealand Guidelines Group guidance on the matter. The aim is to implement an evidence-based programme to better inform the West Coast DHB regarding the detection and incidence of diabetes amongst the community it serves.
Improve uptake of free annual checks	Aim to have 75% of known people with diabetes accessing free annual checks (increase from 50% at present) within the next 2 years	**Partially Achieved** Targets have been set for the Ministry of Health calendar year based measure for Diabetes case detection [number of people who have had their annual primary care diabetes checks as a proportion of the DHB population estimated (using Ministry of health calculations) to have diabetes]. For West Coast DHB, targets for this measure were set as follows for 2004 (Calendar year): • Maori population – 50% • Pacific Island population – 50% • All Other populations – 55% • Total DHB population – 54% Against this measure, the 2004 results for West Coast PHO practices were as follows: • Maori population – 20.8% • Pacific Island population – 35.0% • All Other populations – 61.9% • Total DHB population – 56.1% Using this measure, targets for the non-Maori and non-Pacific Island people was met during 2004. It is recognised that some considerable work still needs to be undertaken to increase the case detection rate for all population groups on the West Coast, and particularly for Maori and Pacific populations, if the rates are to be moved to 75% within 2 years. Strategies and actions identified to endeavour to improve the case detection rate include: • WCPHO primary practice contracts have been aligned to meet the aims and objectives of the Primary Care Strategy for diabetes. • Aim to increase the proportion of people with diagnosed diabetes who receive free annual checks: - Early identification of people with diabetes through targeted screening of patients in a primary care setting. - Target those with known risk factors to ensure maximum effectiveness. - Primary care teams link with the Maori community and with Maori health service

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		providers to focus reciprocal referral and service delivery mechanisms to meet the needs of the Maori community to ensure best health care outcomes.
Improve management of diabetes	Target is for 85% of people receiving their annual checks to have an HBA1c (a measure of how well managed their diabetes is) of 8% or less	**Not Achieved** Case Management results, as determined by the number of people with type I or type II diabetes mellitus on a diabetes register that had an HBA1c of equal to or less than 8%, were below the 85% target for all ethnicity categories on the West Coast in 2004. The result for Pacific Island population appears to be particularly poor, but it should be noted that this result relates to one individual who had their annual check during the reporting period. Case Management results for the West Coast DHB region for the period 1 January – 31 December 2004, (using West Coast PHO data), are as follows: • Maori population – 73.1% • Pacific Island population –0% • All Other populations – 77.5% • Total DHB population – 77.1% The West Coast DHB has the following goals in view in respect to diabetes case management: 1. Slow rate of diabetes progression, reduce incidence of avoidable diabetes related complications 2. Strengthen self-management capability of individuals, family and whanau. In order to achieve this and to endeavour to improve the case management, the West Coast DHB plan to: • Aim to make checks more accessible to population. Trained practice nurses can provide much of the screening process. • Promote free annual checks through the PHO. • Encourage and promote uptake of annual "Get Checked" diabetes screening of "at risk" target groups through the WCPHO, CPH, Maori health and other health providers, with referral on to other appropriate service provider(s) to help effect better management of people with diabetes. • Support for primary practices through closer links and timely access to diabetes support services, including referral to a diabetes nurse educator, dietician, podiatrist, specialist, etc, as appropriate. • Investigate integration of primary and secondary diabetes information databases to improve knowledge about the impact and incidence of diabetes on the West Coast – and in particular, to improve the capture of data for people in the former Special Area Medical practices.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		• Implement appropriate risk mitigation initiatives identified by the Integrated Diabetes Service Working Party and the West Coast DHB with regard to the shortage of General Practitioners within the region, including the development of a GP Rural Training Scheme within the West Coast region; development of training and educational opportunities for the regions stable workforce – including practice nurses - to up-skill their knowledge base relating to the care and management of diabetes; and active encouragement and support (including financial support) of nurses working towards achieving Rural Nurse Specialist status. Feedback from the Integrated Diabetes Service Working Party will be integral to further planning for future local service improvements in diabetes management for individuals and their families/whanau.
Improved detection of diabetes-related eye disease	Target is for 80% of people having their annual checks to have accessed retinal screening within the preceding 2 years.	**Not Achieved** Diabetes Retinopathy Screening results for the West Coast were only slightly below the 80% target for most ethnicity categories on the West Coast in 2004, with the exception of the Pacific Island category where the result was 100% coverage (although, as for Diabetes Case Management above, it should be noted that this result relates to just one individual who had their annual check during the reporting period.). Diabetes Retinopathy Screening results for the West Coast DHB region for the period 1 January – 31 December 2004, (using West Coast PHO data), are as follows • Maori population – 76.9% • Pacific Island population – 100% • All Other populations – 78.8% • Total DHB population – 78.7% Diabetic retinopathy is present at diagnosis for a significant proportion of people with type 2 diabetes. In 2004, WCDHB entered into negotiations with the West Coast PHO to establish a visiting photographic retinopathy screening service on the West Coast. The service commenced with a first clinic in Greymouth during the week commencing 28 February 2005 (with 74 patients screened at this initial clinic). The service is being progressively delivered at main centres throughout the West Coast. This service will improve greater access to retinal screening services, particularly for “at risk” and “high risk” groups of people with diabetes who to date have had to travel off the West Coast for assessment, as well as for others who could not access it at all. The service will also provide an improvement to the sensitivity measurement currently achieved by Physician ophthalmoscopy retinal screening on the West Coast and is expected to bring significant improvement to the longer-term management of diabetic related eye disorders such as blindness and macular degeneration for the people of the

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		region. West Coast DHB's aim for diabetic retinopathy screening is to prevent the development and progression of diabetic eye disease by building upon the recent innovation in having a locally available retinal screening service (both to improve access to retinopathy screening and increasing the proportion of people with diabetes accessing photographic retinopathy screening) and increasing coordination across providers, processes & community resources. Feedback from the Integrated Diabetes Service Working Party will be integral to further planning for future local service improvements in diabetes retinopathy screening for individuals with diabetes.
Priority – Reducing the Incidence and Impact of Cardiovascular Disease		
Work through PHO to implement a monitored approach to providing primary cardiovascular risk assessments of at-risk people at determined time intervals	A mutually agreed plan for risk assessment agreed before July 2005. Establishment of baseline information on the number of cardiovascular risk assessments carried out, smoking status, BMI distribution, cholesterol levels and hypertension.	**Not Achieved** As outlined in our 2005/06 District Annual Plan, the West Coast DHB plans to work with the West Coast PHO to engage General Practices in the development and management of comprehensive individualised care plans for people at risk of, or who have suffered from CVD (and stroke), with support from the WCDHB secondary services as required and inter-sectoral sharing of targeted care plan information. This will also involve the establishment of a dataset to record and monitor 5-year absolute CVD risk care plans. Cardiovascular risk assessment and monitoring for those people with established cardiovascular disease is currently collected at Primary Practice level. There is no data currently captured at Primary Practice level to determine what proportion of men aged 45 and over and women aged 55 and over (and 10 years younger for Maori) have had their five year absolute CVD risk recorded in the last five years, as a primary prevention strategy.
Improve co-ordination between health providers, through the GP liaison role, between primary and secondary services, older people residential services, and Maori health service providers, to help reduce preventable admissions, develop referral guidelines, and encourage utilisation of clinical guidelines	Commencement of planning for cardiovascular disease management begun before July 2005, building on the service development work undertaken in diabetes management.	**Achieved** A Chronic Disease Management work plan has been established for 2005-2007. Part of this involves establishing an integrated continuum of care for cardiovascular disease within this timeframe. The interdisciplinary framework developed in the diabetes management project will form the basis of this project. Representation from primary and secondary medical and nursing providers, community pharmacy, community organisations, patient groups, Maori health providers and the Maori community and WCDHB planners will be involved in the working party.
Develop a West Coast district centre of excellence for stroke rehabilitation in concert	Stroke rehabilitation plan fully developed before July 2005	**Partially Achieved** The refurbishment of the AT&R unit at Grey Base Hospital is yet to commence.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
with the refurbishment of the AT&R Unit at Grey Base Hospital, with a community outreach component for post-discharge follow-up care and monitoring (to lower risk factors for unplanned returns).		A stroke rehabilitation plan is near completion incorporating the New Zealand Guidelines for Management of Stroke, published 2003. The plan crosses the primary and secondary sectors utilising the Assessment and Rehabilitation Nurse Specialist as the pivotal role between the interdisciplinary team members. It has been recognised over the past year that to achieve improved occupational therapy outcomes, the FTE allocation to the unit needed amendment. A reallocation of occupational therapy services was undertaken, and a small increase in overall departmental FTE has meant that the rehabilitation service from July 2005 is able to have a full-time occupational therapist available. This is a 0.5 FTE increase on that which was previously available. It is expected that this will have significant benefits in terms of achieving shorter stays, as well as providing the intense input often needed for these patients.
Health Gain Priority: Reducing Incidence and Impact of Cancer		
Support local and national Cancer Screening Programme initiatives on the West Coast.	Satisfactory audit of WCDHB's cervical screening programme.	**Achieved** Full audit of our office, smear taking services and colposcopy services, by the Screening Unit is scheduled for the 2005/06 year. We have achieved our Health Promotion objections and the running of the regional service as per our Health Promotion plan for 2004-2005.
Education materials produced for people with cancer on treatment options	Materials published and available by December 2004 	**Achieved** Coast health Care supplies generic information handouts to oncology patients on treatment options and relevant information, this is updated regularly and freely obtained from the Oncology Nurse Specialist. Individual information sheets on chemotherapy drugs, including all common side effects are also provided to all oncology patients. This information is produced by the Oncology Department, Canterbury District Health Board, and obtained from the Oncology Nurse Specialist.
Support the further development of palliative care service provision and coordination on the West Coast and work to ensure appropriate coordination and integration or services provided to individuals with cancer.	Palliative Care Coordinator employed by December 2004	**Achieved** The Palliative Care Coordinator is employed on a 0.5 FTE basis and works closely with the oncology nurse, achieving the objectives of improved coordination of palliative care service provision on the West Coast.
Range of chemotherapy available on West Coast expanded	Range of chemotherapy options available at July 2005 indicates that more options are available compared	**Achieved** In April 2004 there was one option available on the West Coast for chemotherapy.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
	with previous years.	By June 2005 there were now 11 options available for chemotherapy treatment based at Grey Hospital. The options are not limited to 11, these treatments are the current patient requirements. All chemotherapy provided on the West Coast is administered by specifically trained nurses within the Outpatient Department under the supervision of the Oncology Nurse Specialist.
Health Gain Priority: Respiratory Health and Reducing Smoking		
Work with Community and Public Health and the West Coast PHO to reduce smoking incidence	Contract for Smokefree promotion signed with PHO before January 2005	**Achieved** Contract signed in December 2004
Improved baseline information on smoking status gathered	Documentation of smoking status of 80% of general practice patients before July 2005	**Partially Achieved** A complete dataset on smoking status for all people enrolled with West Coast PHO General Practices is not yet available. Data collection has been commenced, but different Practices are at various stages of development in respect of data capture for the whole of their registered patients. The Practices do, however, have a robust dataset of risk indicators related to people with diabetes – of which smoking status is one such indicator. Of the 507 on the register of people with diabetes in the 2004 calendar year, 74 were recorded as being smokers; a rate of 14.59%. This is down marginally from the smoking rate recorded among people with diagnosed diabetes in 2003, when the rate was 14.97%. We note that this result is lower than other national surveys would indicate as a likely smoking rate for adult populations and recognised that this is unlikely to be a representative sample for the West Coast population, given that people with diabetes may well have reduced their incidence of smoking in response to the detrimental health effects of this smoking on their condition
Improved availability of smoking cessation services through collaboration with the Ministry of Health	Range of additional smoking cessation services available on the West Coast before March 2005	**Achieved** WCDHB is funding the West Coast PHO to provide additional smoking cessation services, and the WCDHB provider arm also received funding from the Ministry of Health to extend its own smoking cessation services.
Priority - Continuation of Services		
Contracted volumes have been carefully set so as to cover all of the West Coast population's anticipated health needs, mainly based on recent historical demand. Some important aspects are; • Continued provision of maternity services.	For the year 2004-05 at least 90% of the contracted volume will have been delivered within each specialty, and at least 100% of the contracted volume will have been delivered overall.	**Partially Achieved** A variance of less than 5% has not been commented on in regard to these volumes. **Inpatient Volumes: -7% overall** **$ Value: -$210,561** Orthopaedic +6.7% Given the difficulties West Coast DHB has with

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
• Continued provision of community and district nursing services. • Continuation of the funding pool for a limited volume of high cost treatments currently provided on the West Coast. • Continuation of all mental health services currently provided through the provider arm of the DHB. • Continuation of all other services currently provided through the provider arm of the DHB, subject to the implementation of the above-mentioned review of AT&R and aged care services.		recruitment and placement of permanent orthopaedic surgeons, the most was made of an opportunity to undertake additional operating over a four month period to ensure volumes were achieved. As a result we went slightly over volume at end of year. A positive highlight however was the achievement of an additional 10 joints (hips/knees), as part of the orthopaedic initiative funded by government. Gynaecology –13% Some consultant staffing issues were experienced during the year, however we are now fully staffed. Waiting list numbers remain low, due to the low volume of referrals received from GPs. It is likely that this service has reached equilibrium. Paediatric Surgical –27% This service is by contract with Canterbury DHB and the consultant who visits the West Coast DHB went on paternity leave. Unfortunately Canterbury DHB were unable to provide us with a replacement consultant. Paediatric Medical –45% This is an acute, demand driven service. **Surgical Outpatient Volumes: -16% overall** **$ Value: -$222,048** General Surgical –19% Ongoing difficulties with staffing the general surgical service has lead to under-achievement of volumes in this area. Gynaecology –15% As noted in inpatient figures, this service has likely reached an equilibrium. Referral numbers are relatively low, with under-production generally being around follow-up visits. This service has a short waiting list. Orthopaedic –10% Every effort was made to achieve volumes in this area, but unfortunately with locums only available for bursts of time, we did not quite achieve numbers in this area. Overall the West Coast DHB is satisfied that this was a well-achieved result given the consultant staffing difficulties. ENT –18% This service is also provided by Canterbury clinicians, with us being dependent upon their availability. Investigations are currently being undertaken to investigate options for increasing clinic numbers.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		Ophthalmology – 29% In July 2004 Canterbury DHB clinicians withdrew their support of this service. Since that time the West Coast DHB has been reliant on private services provided on an ad hoc basis by ophthalmologists from Nelson. Of note, the private ophthalmologists have provided an outstanding service, massively reducing waiting times and initiating a cataract service via the mobile surgical bus. It is hoped in the 05/06 year to finalise a formal contract for services with either a private consultant or another DHB. Plastic –9% A very difficult service to provide regularly, with nation-wide shortages of consultants in this area. This service is provided by a private consultant from Canterbury who shows a willingness to make best efforts to attain volumes. Strategies are currently being worked on to provide additional clinics. Urology –10% This is a contracted service with Urology Associates. During the latter part of this year further negotiations have been undertaken to increase clinic frequency. **Medical Outpatient Volumes: +16% overall** **$ Value: +$28,534** Dermatology –19% The West Coast DHB remains reliant on a private consultant from Canterbury providing this service. Options for increasing clinics to meet demand are currently being looked at. Neurology –51% The West Coast DHB remains reliant on services from Canterbury for this service. Options for increasing clinics are currently being looked at. **Other:** Other Medical Clinics –15% A demand-driven service. Locum physicians have recently held additional clinics to try to address the shortfall. Again, ability to either flex up existing staff, or obtain locums has influence on this. Emergency Dept +17% Steady increase in attendances over the past number of years has been exacerbated by a shortage of GPs, inability to get timely GP appointments, and in some instances, cost of GP services has meant A&E has become a fall-back

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		position for some patients. Increasing tourist numbers also impact on the service. General Surgery MOP –11% The inability to replace the surgical registrar position from December 2004 meant a temporary reduction in minor outpatient procedures. Locum general surgeons have now picked up this shortfall in service. Gynaecology High Cost Minor –24% Demand driven service. Urology – Lithotripsy –17% Reduced services were provided by the mobile lithotripsy bus over the 04/05 year. Dietitian –32% Volumes had been increased for the 04/05 year, however with new staff, and a tighter process for follow up criteria, less attendances have been achieved than purchased. The service has shown innovation in running drop-in clinics once a week, which have been well utilised by motivated members of the public. Occupational Therapy – 45% This under-production is in the main due to data issues which were resolved throughout the 04/05 year. A number of incorrect reporting procedures were being undertaken, significantly increasing the reported number of attendances in previous years. It is believed the level of attendances actually attained for the 04/05 year is more realistic, rather than the actual volume set. Physiotherapy +11% Over-production in this area pertains directly to over-production by the orthopaedic inpatient service, having a direct flow-on effect. Social Work –10% Ongoing staffing ups and downs throughout the year contributed to this under-achievement. Speech Therapy –18% The West Coast DHB believes this was a realistic achievement for a sole practitioner given the very high demands of the inpatient rehabilitation service. There are no locums available for this service and a balance is tried to be achieved between essential and desirable service provision. Demand on services for inpatient areas can create a significant flow-on effect to ability to provide outpatient services.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		Oncology – Chemotherapy +238% The Oncology/Palliative Care Nurse has upskilled and now can deliver a wider range of services. This has had major benefits for patients who no longer have to travel to Christchurch for chemotherapy. Service Coordination – Aged -44% The main cause of Service Coordination being under volume is as a result of reporting of Home Support Reviews not being up to date. This has been the result of printouts from the Ajexus software programme giving inconsistent information wherein not all clients to be reviewed are listed. The current version of Ajexus (V3.65) is to be replaced which we are assured will rectify the difficulty. Home Support Reviews are on an annual basis, generally carried out by telephone for non-complex packages of care which make up the bulk of the reviews. For more complex packages of care, reviews are face to face, quite often on a more regular basis than annually – these are up to date. AT&R Inpatient –20% A demand driven service. If surgery, particularly acute orthopaedic surgical volumes are reduced there is a flow-on effect through the AT&R service. Very little acute orthopaedic surgery has been undertaken at the West Coast DHB since the departure of our second surgeon in August 2004. Needs Assessment AT&R –25% A demand driven service. AT&R Outpatients –8% A demand driven service. AT&R Outpatient (Day) –60% Reduced referrals and patient numbers from the community. The West Coast DHB also competes with private providers for community- based referrals.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
Priority - Waiting Times and Access to Elective Surgical Services		
Patients referred to core elective surgical services provided by the provider arm of the West Coast DHB should not wait longer than 6 months for first specialist assessments. It is not always possible to ensure that all patients referred to clinics provided by visiting specialists do not wait longer than 6 months for first specialist assessments due to the infrequency of some clinics.	Target is for as close to 100% (of patients not waiting longer than 6 months for first specialist assessments) as is practical given these circumstances. Explanations will be provided for any variances.	**Not Achieved** June 2005 MOH data shows that the West Coast DHB has 436 (10.5%) patients waiting longer than six months for their first assessment. Of those patients, June 2005 WCDHB data shows that 347 of these are waiting for visiting specialists, not WCDHB resident consultants. Prime areas of difficulty were: Urology Plastic Surgery ENT Dermatology In terms of West Coast DHB provided specialties all but seven of the remaining patients waiting longer than six months were in the general surgery specialty. This clearly represents the difficulties that have been experienced in providing cover in this service over the past few years. On going discussions continue between the DHBS for improving services here on the West Coast.
Patients who have been offered[2] publicly funded treatment by the provider arm of the West Coast DHB should not wait longer than 6 months for that treatment.	Target is for as close to 100% (of patients who have been offered[3] publicly funded treatment not waiting longer than 6 months for that treatment) as is practical given these circumstances. Explanations will be provided for any variances.	**Achieved** May 2005 data shows that the West Coast DHB has achieved well in this area for the last six months, with no improvement being required by the Ministry of Health. 25 patients remain waiting at the end of May (1.9%) – many of these have deferred from choice or have some medical problem precluding surgery in the near term.
Priority - Safety and Quality Standards		
An annual quality plan in order to enable a focused approach to quality improvement throughout the organisation.	Publication of the plan before July 2005.	**Achieved** Report has been developed and is being monitored monthly
Certification against relevant standards. Such as; • NZS 8134:2001 "Health and Disability Standards" • NZS 8143:2001 "National Mental Health Standards" • NZS 8142:2001 "Infection Control Standards" • NZS 8141:2001 "Restraint	Certification against the listed standards by July 2005.	**Achieved** Certification achieved in August 2004, and further reviewed by auditors in February 2005

[2] "offered" in this context means being given certainty of treatment under the National Booking System.
[3] "offered" in this context means being given certainty of treatment under the National Booking System.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
minimization and Safe Practice Standards".		
Priority - Hygiene Standards		
Minimisation of the incidence of Hospital Acquired Blood Infections through stringent safety procedures.	The target is to keep Hospital Acquired Bloodstream Infections as a percentage of all Inpatient Admissions less than 1%.	**Achieved** Currently incidence of Hospital Acquired Infections is at 0%
Priority - Patient Satisfaction		
Patients will be very satisfied with the services they receive from WCDHB	The target is to have 85% of inpatient satisfaction surveys and 85% of outpatient satisfaction surveys rated as either "good" or "very good" as measured by the Health Monitoring Directorate of the Ministry of Health. (200-03 target 85%).	**Achieved** Currently Outpatient satisfaction is at 91% and Inpatient satisfaction is at 92%
Priority - Preparedness for a Major Incident or Emergency		
The West Coast DHB is currently preparing a major incident management plan to ensure that services can continue if a major incident occurs and will implement any requirements of the plan during the 2004-05 financial year.	Publication of the plan before July 2005	**Achieved** Plan has been developed and will be tested through a comprehensive exercise to be undertaken in September/October 2005.
Priority - Implementation of the Primary Healthcare Nurse Innovation Project: Neighbourhood Nursing in Reefton.		
The project aims to expand the Primary Healthcare Nurse role as a key component in the delivery of health services in small rural communities. It will encompass a diverse range of nursing services including Public Health, District, Practice and General Nursing out side of the hospital setting. The role will also complement the existing Rural Nurse Specialist roles.	Satisfactory annual report presented to the Ministry of Health.	**Achieved** A report on this project was submitted to the MOH as part of our accountability reporting requirements. The report indicated that the project has been revitalised, and while the scope and objectives as originally agreed with the MOH remain unchanged, the location of the pilot has now changed. There is considerable optimism that this pilot project will set the framework for the model for future delivery of primary health nursing services on the West Coast.
Priority - Continued Monitoring and Improvement of the Mental Health Service		
Compliance with these standards ensures that quality and availability of mental health services is maintained.	The aim is to achieve as close to 100% compliance as is practical. Explanations will be provided for any variances.	**Achieved** The mental health service conducts an active continuous quality improvement programme aimed at ensuring mental health standards are met in all facets of its operations.

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
Priority - Human Resources		
Areas such as equal employment opportunities, managing cultural diversity, management of change, employee assistance programs, occupational safety and health, training opportunities and scholarship support will all be actively promoted and supported by the West Coast DHB.	Narrative report	**Partially Achieved** EEO policy and procedures are in place, all employment opportunities include all principles of equity. Initiatives include, involvement in Future Workforce (DHBNZ), a local Maori Workforce Development Plan, and Ethnicity data collection training. **Managing Cultural Diversity** **Partially achieved** Cultural policy and procedure promotes an environment within which individuals are aware of the unique cultural needs and preferences of others whether staff or patient. Maori workforce development plan is aimed at improving numbers and staff mixes. **Management of change** **Partially Achieved** Challenges face the WCDHB in developing the workforce without constraining the ability to address local health priorities. Retention of skills within the workforce is the focus. Reviews of the workforce reflect a strategy of skills retention rather than redundancy as the desired outcome. The ability to prepare for and be aware of the continual need to adapt and change in today's working environment is paramount. Projects like the "Neighbourhood Nurses" are trialling new methods of working, in particular the need for nurses to work collaboratively to address specific health needs in communities. **Employee assistance programmes** **Achieved** EAP is part of the H & S strategy. EAP provides support to employees. It encourages the workforce to address issues that may affect workplace performance. **Occupational safety & health** **Partially Achieved** The focus of Occupational H & S is on a healthy and safe workplace, to include the welfare of staff. Current initiatives include the addition of 0.5 FTE to team, continued tertiary level ACC partnership, and working towards mandatory zero lifting policy. **Training opportunities** **Partially Achieved** Mandatory training schedule is on track for the current year. **Delayed** The staff training and development committee that advised Senior Management on matters relating to staff training and development needs to be re-established in the near future to further review, evaluate and develop current mandatory programme. **Delayed** Training needs analysis completed for Management at 4th tier and above, with view to

Output	Performance Target to 30/6/05	Actual Performance to 30/6/05
		being implemented within the short term. **Scholarship opportunities** **Not achieved** Intended initiative to offer local Maori bonded training opportunities within the range of health roles available at DHB.
In addition to recruiting, maintaining, and managing its own work force, the West Coast DHB will support and assist other organisations such as GP practices and the West Coast PHO in their efforts to attract and retain medical staff to West Coast.	Narrative report includes at least two examples of support and assistance to other organisations for recruitment and retention	**Partially Achieved/Delayed** Current initiatives include collaboration with CDHB, exploring joint appointments or collaborating with rostering where gaps are identified.
Where practical, the West Coast DHB will also work with non-health employers to promote common interests in the recruitment and retention of qualified employees.	Narrative report	**Delayed** An agreement has been achieved with local secondary schools to work towards collaborating when recruiting, looking at potential employment for husbands, wives or partners of applicants. **Not Achieved** An initiative to work with Tai Poutinu Polytechnic and other educational organisations collaboratively to provide opportunities for Maori to train in health careers.
Expand the DHB Professional Development Programme to meet the NZ Nursing Council's professional recognition framework, including the development of Nurse Practitioner roles.	PDP approved by NZNC by December 2004	**Achieved** The Professional Development and Recognition programme for Nurses (PDRP) is now in place. The role of Professional Practice Nurse has been appointed to provide support and guidance to all those who access the programme. Nurses are actively being encouraged to take part in this programme.

Objectives and Performance Targets as a Provider

The provider arm of the West Coast DHB is responsible for the delivery of the services contracted by the Purchasing arm of the West Coast DHB. The specific details of these services are detailed in the West Coast DHB Annual Plan.

The following statistics give an indication of the scope and scale of the West Coast DHB's provider arm activities in 2004/05;

- 6,170 Patient discharges from hospital (raw inpatients /day patients purchased on a WEIS and non-WEIS basis)
- 3.36 Average length of stay (days) for medical and surgical patients
- 2,194 Total surgical operations performed in theatre (1,714 of which were non-acute)
- 16,370 Specialist outpatient attendances (of these 5,266 were first attendances)
- 12,870 Emergency Department attendances
- 56,883 Outpatient and domiciliary personal health attendances by allied health services (excluding X-ray, Laboratory, Special Area Medical Officer & GP Contacts).
- 7,975 Outpatient and domiciliary disability support attendances by specialist and allied health services
- 41,860 Meals on wheels were delivered Coast wide
- 11,376.5 Home help hours to personal health and maternity clients
- 282 Babies were delivered in hospital
- 4,659 Children served by school dental service
- 1,273 Children served by public health nursing service
- 28,299 Days of care for rest home and long stay patients
- 5,804 Inpatient mental health days of care
- 21,560 Face to face attendances by outpatient and community mental health services (including CAMHS, A&D, Child & Youth, etc)
- 3,292 Assessment Treatment and Rehabilitation inpatient bed days

Services provided included surgical, medical, women's health, child health, older persons health, disability support, mental health, intellectual disability, public health, X-ray, laboratory, GP services, child development, stomal care, palliative care, aged care service co-ordination, personal care, lithotripsy, pharmacy, orthotics, cervical screening, etc.

The provider arm utilised the following resources in achieving these outputs;

- 1,012 Number of people employed by the West Coast DHB (595.1 FTEs).
- $39m Of total assets.
- Hospitals located at Westport, Reefton, Greymouth and Hokitika
- Rest Homes at Westport and Reefton.
- GP Services at Ngakawau, Westport, Dobson, Greymouth, South Westland (Whataroa).
- District Nurses / Public Health Nurse centres at Westport, Hokitika, Greymouth and Reefton.
- Rural Nurse Health centres at Karamea, Moana / Otira, Whataroa / Franz Josef, Hari Hari, Fox Glacier and Haast.

Outputs reflecting the success in achieving this aim are referred to as "Provider Arm Outputs"

Governance Operating Statement for the 12 months ended 30 June 2005

	Board Budget June 2005	Board Actual June 2005	Board Actual June 2004
Revenue	1,008	1,117	998
Operating Expenses	(1,134)	(921)	(795)
Net Operating Surplus (Deficit)	(126)	196	203

Funding Operating Statement for the 12 months ended 30 June 2005

	Board Budget June 2005	Board Actual June 2005	Board Actual June 2004
Revenue	72,477	75,635	70,238
Expenditure			
• Personal Health	(51,097)	(52,601)	(52,045)
• Mental Health	(9,533)	(9,600)	(9,272)
• Public Health	-	(176)	-
• Disability Support	(9,477)	(10,175)	(7,207)
• Other Services	(992)	(1,061)	(1,002)
Net Operating Surplus (Deficit)	1,378	2,022	712

Provider Operating Statement for the 12 months ended 30 June 2005

	Board Budget June 2005	Board Actual June 2005	Board Actual June 2004
Revenue	52,311	53,018	52,013
Operating Expenses	(51,395)	(52,600)	(48,701)
Operating Surplus (Deficit) Before Depreciation, Capital Charge Interest & Non Recurring Items	916	418	3,312
Depreciation	(2,678)	(2,615)	(2,683)
Capital Charge	(1,300)	(948)	(1,320)
Interest Expense	(870)	(749)	(660)
Operating Surplus (Deficit) Before Non Recurring Items	(3,932)	(3,894)	(1,351)
Net Operating Surplus (Deficit)	(3,932)	(3,894)	(1,351)

Summary of Revenue and Expenditure by Output Class

	Provider	Governance	Funder	Eliminations	Result
Revenue	53,018	1,117	75,635	46,596	83,174
Expenditure	56,912	921	73,613	46,596	84,850
	(3,894)	196	2,022	0	(1,676)

Helen Clark visits West Coast DHB in July
Pictured are Damien O'Connor, MP for West Coast/Tasman, Helen Clark, Prime Minister, Gregor Coster, Chair, WCDHB and 3 Medical Students on the Training Programme which commenced on 26 April 2005.

STATUTORY INFORMATION

NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

Section 42(3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to provide the information outlined below in their annual reports. These requirements are in addition to those specified in Section 41 of the Public Finance Act 1989. We have shown them here for ease of reference, but the information may be incorporated into other parts of the annual report, for example, the Board Members report, the statement of service performance or the notes to the accounts.

Personnel Policies

The following Board policies contribute to and assist the Board in meeting its objectives as a good employer. The policies provide guidance and support to staff and management to ensure all employees are treated fairly and equitably:

- Recruitment
- Employee Assistance Programme
- Equal Employment Opportunity
- Good Employer Procedure
- Orientation
- Prevention Of Harassment
- Smoke-Free Workplace Policy And Procedure
- Staff Code Of Conduct
- Staff Discipline, Suspension And Dismissal Procedure
- Staff Guidelines On Cultural Safety
- Training And Development
- Performance Management
- Leave

Other Objectives

During 2005 the West Coast DHB was actively engaged in developing its District Annual Plan for 2005-2008.

This plan is aligned to the current District Strategic Plan (2002-2012) which involved extensive community consultation on identifying key health gain areas for the West Coast population upon which the DHB should focus its resources. The West Coast DHB has also been developing a new District Strategic Plan for 2005-2015.

A comprehensive Health Needs Analysis was carried out in October 2001 to underpin the planning processes required of the DHB. This was updated in 2004 to inform future planning 2004/05.

The plans and other activities ensure the West Coast DHB has materially complied with all statutory objectives outlined on the following pages.

STATUTORY OBJECTIVE	EXTENT TO WHICH IT HAS BEEN MET
To improve, promote, and protect the health of people and communities	**Primary Health** West Coast PHO was established 1 October 2002 thus meeting requirements and objectives of the Primary Health Strategy. **Oral Health** Extensive work has been undertaken to improve oral health outcomes for West Coasters. This includes a review of the School Dental Service, a Strategic Asset Management Plan for Child and Adolescent Oral Health Services, Dental Therapist run dental clinics for adolescents in Hokitika, Adolescent Oral Health Regional Coordination Service, work to promote water fluoridation to West Coast councils and ongoing relationship building with providers. **Child Health** Leadership and co-ordination on child and youth health services provision and planning has been strengthened through the development of the WCDHB Child and Youth Heath Committee, with collaboration amongst primary and secondary health care providers, community agencies and community representatives. This has included significant input into the planning of the Meningococcal B Vaccination Campaign which continues to be a focus in improving Child and Youth Health in 2005/06, as well as input into the implementation of the National Immunisation Register. **Cardiovascular (CVD)** The West Coast DHB is actively involved in a number of initiatives aimed at reducing the impact and incidence of cardiovascular disease, including a reduction in smoking rates and improving nutrition and exercise. This will be an evolving process over time. West Coast DHB aims to establish a CVD Service Development Group in 2005/06 to investigate best practice in CVD risk reduction strategies for our region. **Diabetes** West Coast DHB established an Integrated Diabetes Service Working Party in 2004/05; the work of which is being used as the basis for effective planning and moving ahead with improving diabetes services on the West Coast in 2005/06 and beyond. The group has multi-sectoral representation of both consumers and health service providers and has merged its planning role with the advisory and monitoring role of the Local Diabetes Team to give diabetes services integration a greater impetus. It is hoped that this Group will also serve as a model for other service improvement focus groups into the future – including those to be established to look at cardiovascular disease, cancer control, palliative care and respiratory health services. West Coast DHB secured the services of a diabetes retinal screening service through the West Coast PHO. This service commenced in February 2005. **Others** Numerous other examples are given in the Statement of Service Performance in this Annual Report.

STATUTORY OBJECTIVE	EXTENT TO WHICH IT HAS BEEN MET
To promote the integration of health services, especially primary and secondary health services	Increased liaison and integration has occurred through the establishment of the PHO and a review of DHB owned primary and community services is planned. The West Coast DHB and West Coast PHO have established a Primary Health liaison position to further improve the integration between and within the West Coast primary and secondary sectors; this role has been filled by a General Practitioner, West Coast DHB and the PHO have shared information on a number of initiatives, including improvement of diabetes services and review of ambulatory sensitive admissions data to investigate possible strategies to reduce the incidence of such potentially avoidable cases.
To promote effective care or support for those in need of personal health services or disability support services	The implementation of the previous year's service review recommendations commenced in 2004/05. • Mental Health Support Services Review • A&E Review • Professional and service standards are met, and subject to ongoing review • West Coast Improving Services for the Elderly • Disability Implementation Plan
To promote the inclusion and participation in society and independence of people with disabilities	The West Coast DHB, as a good employer, has developed a policy to support and promote equal employment opportunities for people with disabilities and ensure the absence of discrimination against individuals. The Disability Services Advisory Committee advises the Board on disability issues. A Disability Action Plan to ensure the DHB promotes opportunity and access for disabled people accessing DHB facilities and services has been developed and implementation is underway.
To reduce health disparities by improving health outcomes for Maori and other population groups	***Consultation with Maori communities*** In April 2005, consultation with the Maori communities on Tai Poutini regarding the WCDHB Draft District Strategic Plan 2005-2011 occurred. ***Health Needs Assessment*** Although this has not occurred yet, we are planning to again consult with Maori communities in 2005 regarding a health needs assessment. ***Maori Health Plan*** A Maori Health Plan has been completed. The Maori health plan is updated through the Hospital Advisory Committee and Community and Public Health Advisory Committee. The GM Maori Health has made presentations to both groups, and progress on the Maori Health Plan is reported back to the Board via the Chairpersons of these respective committees. In addition, local Runanga are kept informed on developments. A monthly report is accessible to the public via the WCDHB website ***Ethnicity Data Collection*** Ethnicity data collection training for WCDHB staff took place in August 2005.A second session of ethnicity data collection training is scheduled for December 2005.

	Increasing staff and community awareness of the importance of reducing disparities Ongoing activities are in place to raise the awareness of WCDHB staff of the importance of reducing disparities. • Te Pikorua Cultural Training • Treaty of Waitangi and Maori health issues • Brief Introduction to Maori health available at all mandatory orientation for new staff **Memorandum of Partnership with local Maori** The WCDHB has in the past had regular meetings with Poutama Ora, the Manawhenua Health Committee to the West Coast DHB. This group was made up of representatives from Nga Papatipu Runanga, and Rata Te Awhina Trust. We received correspondence from Nga Papatipu Runanga indicating they would like a review of the Poutama Ora kaupapa, membership, and it's relationship with the West Coast DHB. Local Runanga have restructured their Manawhenua Health Committee and we have also been informed by the local Runanga that a new Manawhenua Health Committee has been established. This will include two members from each Runanga and two members from Nga Maata Waka. Essentially there is a new committee that will be advising the WCDHB Board who have their first Inaugural meeting on the 20 September 2005. The WCDHB is in regular contact with local Runanga and meet regularly to discuss Maori health issues.
To reduce, with a view to eliminating, health outcomes disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders	The PHO established on the West Coast is the primary vehicle for the West Coast DHB to address disparities in health outcomes as identified in the Health Needs Analysis and Strategic Plan. Improved funding through the PHO and targeted integrated health programmes will assist in addressing inequalities.
To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services	The DHB has consulted extensively in early 2005 with local communities (both geographic and communities of interest) during the development of the 2005-2015 District Strategic Plan and has incorporated results of that consultation into the District Strategic Plan.
To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services	The DHB is committed to community engagement and participation by the community in service planning and where significant changes are likely. Statutory Committees of the Board have significant community representation and in addition the Board has a Mental Health Advisory Committee. Public forums were held to discuss the Health of Older People and the Mental Health Support Services. A West Coast Mental Health Forum is held regularly.
To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations	The Board monitors ethical and quality standards performance and it has fully met this objective.
To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations	The Board meets all requirements for the operation of its facilities including waste management and air discharge. It maintains its facilities to a good standard.

The NZ Public Health and Disability Act 2000 section 23 defines the functions of a DHB. The West Coast DHB has given effect and intends to give effect to its statutory functions as listed below.

STATUTORY FUNCTION	1. HOW HAS IT BEEN GIVEN EFFECT AND 2. HOW THE BOARD INTENDS TO EFFECT IT
To ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement	1. Crown Funding Agreement deliverables met. 2. Board intends to meet the requirements of all funding agreements that it enters.
To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities	1. The Board is actively involved in; (a) DHBNZ, an association of DHBs that acts for DHBs on matters of common interest; (b) South Island Shared Services Agency, jointly owned by the South Island DHBs to assist with health planning and to provide support services to the DHBs; (c) Management and staff are involved in numerous forums with the Minister of Health, other DHBs, and local agencies. 2. Primary Secondary sector integration and inter-agency co-operation will be the main local approaches.
To issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of the two functions above	1. Via print and news media, website and consultation. 2. Continue with (1) above.
To establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement	1. The Board employs a General Manager, Maori Health at the Executive Management Team level and meets formally with representatives of Nga Papatipu Runanga. There is Maori representation on all advisory groups. 2. The West Coast DHB continues to support the local Maori provider (Rata Te Awhina Trust). 3. A whanau facility has been constructed and opened in March 2004. A needs assessment of the Maori population is planned for 2005.
To continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori	The West Coast DHB is developing strategies that will improve the recruitment, training and retention of Maori staff. The West Coast DHB has developed a Draft WCDHB Maori Workforce Development Plan 2003-2009. The main focus of this plan is to increase the number of Maori staff in the organisation and to improve the skills of the Maori health and disability workforce.