WEST COAST DISTRICT HEALTH BOARD

Te Poari Hauora a Rohe o Tai Poutini

ANNUAL REPORT

FOR THE YEAR ENDED
30 JUNE 2006

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Front page photo of Butler Range & Whataroa River
Photographed by Martin London, GP, South Westland.

CHAIRMAN'S AND CHIEF EXECUTIVE'S REPORT

The 2005/2006 year was time of considerable change for the West Coast District Health Board with the adoption of the vision: ***"To be the New Zealand centre of excellence for rural health services".***

Overall the DHB is expanding its vision of how it can positively influence the health of West Coasters. In the past year the Intersectoral Forum was established consisting of community leaders and representatives from key government agencies. This forum is enabling the DHB to work towards its goal of improving the everyday health of West Coasters by encouraging key organisations to collaborate to positively influence the well-being of their constituents by the decisions they make.

The West Coast DHB believes it offers clinical services comparable to any other region. Improved recruitment performance has seen more stable clinical staffing in many areas, with gains in productivity. The DHB has been a strong performer in delivering elective services. The DHB is also focussed on increasing the wellness of its community in order to reduce illness.

Spring into Action is a physical activity programme that has now been rolled out across the region and has seen hundreds if not thousands of West Coasters moving their way to better health.

Working with the West Coast PHO has meant that more West Coasters than ever before have access to subsidised primary care visits and reduced cost prescriptions. The West Coast PHO has began to make some important strides towards making excellence in rural primary care a reality on the West Coast, especially in the management of chronic conditions.

In the past year the DHB has launched Buller Health, a unique model of health care delivery whereby Buller Medical Services and Buller Hospital combined into one cohesive unit designed to ensure that the people receive maximum health benefits. Both services now report to one manager based in Westport, enabling this service to be much more responsive to the community's needs.

As part of this process the DHB will be working towards the implementation of the Buller Health Plan which is currently in draft form. This plan aims to operationalise the DHB's strategic plan in a Buller context.

This past year has also seen the DHB take great strides forward in terms of its ability to not only stay current with developments in Information Technology but to look at how innovation in Information Technology can help to overcome the isolation experienced in this region.

The ability to electronically connect rural clinics around the region has meant that clinicians working in some of the most remote parts of the West Coast are just a few key strokes away from being able to link in with medical professionals anywhere, with benefits to clinicians and patients alike.

These systems have not just been a boon to staff but now mean that x-rays can be electronically sent to hospitals anywhere in the country so that patients travelling out of the region for treatment can be assured their files will arrive before them giving clinicians an opportunity to formulate a treatment plan in emergency situations even before the patient arrives.

As part of the strategic shift that has occurred over the year, and to ensure the organisation can continue to meet the needs of West Coasters for years to come, the DHB began the Grey Base 2020 project.

This project saw the DHB consult with staff and the public about what they see as the future of Grey Base Hospital.

In 2007 the DHB plans to present a business case to the Ministry of Health regarding whether to rebuild or reconfigure the hospital in order to have a facility and staff capable of keeping pace with the region's changing population and health needs.

The DHB was extremely excited to finally receive Ministerial sign off for a purpose built Dementia Care Unit to be built at Grey Base Hospital. Once this facility has been completed the DHB will fully exit the Seaview Hospital site in Hokitika.

The DHB aims to have the new Dementia Care Unit open in Greymouth by the end of 2007.

The plan for 2006/2007 is to build on the success of the past 12 months and continue to work towards creating a sustainable health service for years to come and to improve the health of the people in this region.

IN MEMORY

In September 2006 serving West Coast District Health Board member Glenys Baldick passed away.

Glenys was appointed to the Board in 2004 and in 2005 spent six months serving as Acting Chief Executive.

The experience and intelligence she brought to her roles with the DHB will be greatly missed by Board members and staff alike.

Her passion for the health sector saw her spend 14 years as the Chief Executive of Nelson Marlborough DHB until ill health forced her to retire in 2004.

Glenys started her career in health as a nurse at Wairau Hospital eventually working her way up to CEO with Nelson Marlborough DHB. Her contribution, of course, went much wider than Nelson Marlborough and the West Coast as she served on many national committees over the years, and in fact chaired a ministerial committee up until earlier this year.

Her commitment to health took her beyond New Zealand's shores spending six months in Mongolia on behalf of the World Health Organisation in 1997 and accompanying the Minister of Health to Geneva for the World Health Congress in 2003.

Glenys's sense of humour, quick wit and passion for health will be greatly missed.

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

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High Street
GREYMOUTH

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POSTAL ADDRESS

PO Box 387
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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

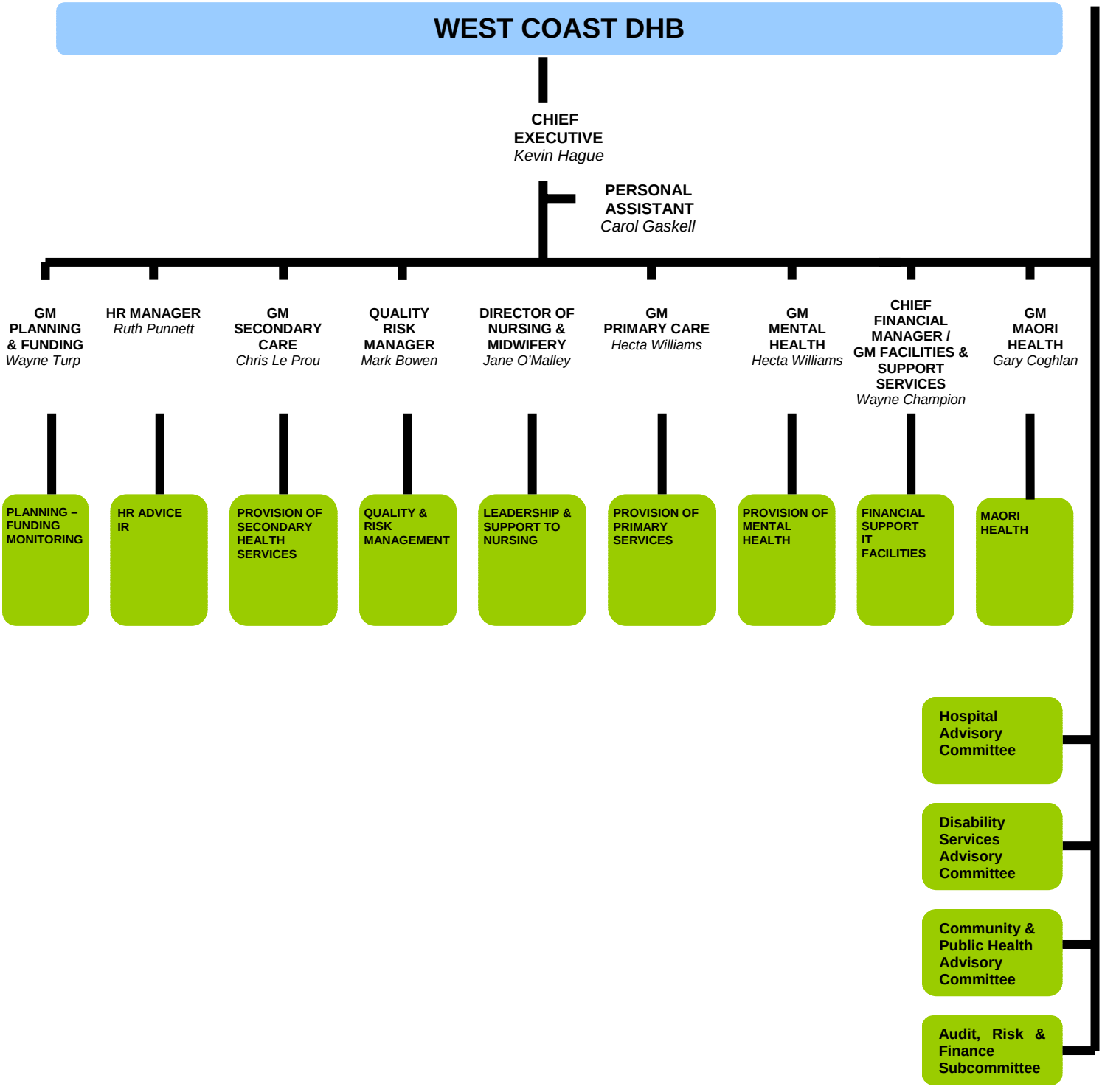
Hannan & Seddon
Guinness Street
GREYMOUTH

Telephone: (03) 768 4169

VISION STATEMENT

"To be the New Zealand centre of excellence for rural health services"

ORGANISATIONAL STRUCTURE 2006



WEST COAST DHB BOARD MEMBERS

Board Member	Current Interests	Special Responsibilities
Professor Gregor Coster ***Re-appointed October 2004***	• Deputy Chair - PHARMAC • Director - Cornwall Management Limited	• WCDHB Chairman • Member - HAC • Member - CPHAC • Member – DSAC • Member - Audit, Risk & Finance Subcommittee
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.	• WCDHB Deputy Chair • Chair - HAC • Member - Audit, Risk & Finance Subcommittee
Dr Carol Atmore ***Elected Member November 2004***	• Employed by WCDHB as a General Practitioner at Greymouth Medical Centre and as GP Liaison Officer • Member – ASMS - Association of Salaried Medical Specialists • Contracted as Clinical Advisor to the Clinical Directorate of the Ministry of Health in the Chronic Condition Management area	• Chair - CPHAC
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 • Trustee - Nelson Hospital Equipment Trust	• Deputy Chair - HAC
Ms Robyne Bryant ***Elected Member November 2004***	• None	• Member - Audit, Risk & Finance Subcommittee • Member - CPHAC
Mrs Julie Kilkelly ***Elected Member November 2004***	• Member - Pharmaceutical Society Incorporated • Member - New Zealand College of Pharmacists • Director - Kilkelly Kartage Ltd • Trustee - West Coast PHO Board • Director - Olsen's Pharmacy (2002) Ltd	• Deputy Chair - CPHAC
Mr Mohammed Shahadat ***Elected Member November 2004***	• Principal Partner - Murdoch James and Roper • Trustee - West Coast Development Trust	• Chair - Audit, Risk & Finance Subcommittee • Deputy Chair - 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
Mr Brian Wilkinson ***Elected Member November 2004***	• Member – Pharmaceutical Society Incorp. • 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:

Board & Advisory Committee Members

West Coast DHB

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

Audit, Risk & Finance Subcommittee

Mohammed Shahadat (Chair)
Professor Gregor Coster
Ms Robyne Bryant
Dr Christine Robertson

Hospital Advisory Committee

Dr Christine Robertson (Chair)
Glenys Baldick (Deputy Chair)
Professor Gregor Coster
Kathryn Cannan
Barbara Beckford
Elizabeth Rock
Richard Wallace
Brian Wilkinson

Disability Services Advisory Committee

John Vaile (Chair)
Mohammed Shahadat (Deputy Chair)
Professor Gregor Coster
Maureen Frankpitt
Gloria Hammond
Patricia Nolan
Elinor Stratford
Ned Tauwhare

Community & Public Health Advisory Committee

Dr Carol Atmore (Chair)
Julie Kilkelly (Deputy Chair)
Professor Gregor Coster
Barbara Beckford
Cheryl Brunton
Barbara Greer
Sharon Ransom
Greville Wood

Committee Meets

Audit, Risk & Finance Committee	Quarterly
Hospital Advisory Committee	6 weekly
Community & Public Health Advisory Committee	6 weekly
Disability Services Advisory Committee	Quarterly

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.

GOVERNANCE PHILOSOPHY

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 Boardroom.

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.

The first WCDHB meeting at Te Tauraka Waka a Maui Marae, Bruce Bay on 7 April 2006
From left: Kevin Hague, CEO – Ron Paterson, Health & Disability Commissioner –
Ria Earp, Deputy Director-General Maori Health – Gregor Coaster WCDHB Chair.

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 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 and community appointees. Board members were selected by their colleagues to sit on the committees. The Chair of the Board is a member of all advisory committees while other 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.

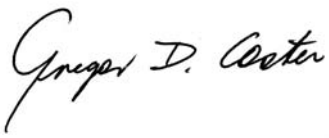
The Chairs of all committees recognise the considerable input from staff and wish to record their thanks for work well done.

STATEMENT OF RESPONSIBILITY FOR THE YEAR ENDED 30 JUNE 2006

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 2006, 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
Mana Arotake Aotearoa

AUDIT REPORT

TO THE READERS OF WEST COST DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2006

The Auditor-General is the auditor of West Coast District Health Board (the Health Board). The Auditor-General has appointed me, Tony Uttley, 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 2006.

Unqualified opinion

In our opinion the financial statements of the Health Board on pages 16 to 76:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health Board's financial position as at 30 June 2006;
  - 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 20 October 2006, 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

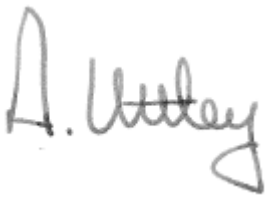
The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board as at 30 June 2006. They must also fairly reflect the results of its operations 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 of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

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 have carried out an assurance related assignment in the area of conflicts of interest, which is compatible with those independence requirements. Other than the audit and this assignment, we have no relationship with or interests in the Health Board.



Tony Uttley
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of West Coast District Health Board (the Board) for the year ended 30 June 2006 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 20 October 2006 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 2006

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 and Statement of Intent. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of these financial statements.

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 lower of cost or net realisable value as per SSAP 17.

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. 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.

The last of the finance leases were reported in the 2004/05 financial year.

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.

Picture Archiving Communication System (PACS) – Go live day 5 April 2006
From left: Glenda Chamberlain, MRT – Miles Roper, Acting Manager Information Technology – Wayne Champion, Chief Financial Manager

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Budget June 2006 $000	Actual June 2006 $000	Actual June 2005 $000
Revenue		92,820	93,183	83,174
Expenses (excluding capital charge)		91,216	92,234	83,902
Capital charge	16	1,600	1,106	948
OPERATING SURPLUS/(DEFICIT)	1	4	(157)	(1,676)
NET SURPLUS/(DEFICIT)		4	(157)	(1,676)

STATEMENT OF MOVEMENTS IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Budget June 2006 $000	Actual June 2006 $000	Actual June 2005 $000
EQUITY AT BEGINNING OF THE PERIOD		13,886	13,213	13,880
Net surplus/ (deficit) for the year		4	(157)	(1,676)
Movement in Asset Revaluation Reserve	3(d)	-	4,216	9
Total recognised revenues and expenses for the period		4	4,059	(1,667)
OTHER MOVEMENTS				
Contributions from owners	3(a)	1,000	-	1,000
EQUITY AT THE END OF THE PERIOD		14,890	17,272	13,213

The accompanying statement of accounting policies on pages 16 to 18, and notes on pages 23 to 31 form part of these financial statements.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2006

	Notes	Budget June 2006 $000	Actual June 2006 $000	Actual June 2005 $000
EQUITY				
Share Capital	3(a)	46,827	44,147	44,147
Retained earnings/(Accumulated Deficit)	3(b)	(40,525)	(39,683)	(39,527)
Trust funds	3 (c)	45	40	41
Asset Revaluation Reserve	3(d)	8,543	12,768	8,552
Total equity		14,890	17,272	13,213
REPRESENTED BY:				
ASSETS				
Current assets				
Cash		3,373	5,445	3,672
Short Term Investment		-	-	3,400
Receivables and prepayments	4	6,965	1,931	6,299
Inventories	5	578	601	597
Patient & Restricted Trust Funds	14	6	60	72
Properties Intended for Sale		207	264	205
Total current assets		11,129	8,301	14,245
Non current assets				
Investments	6	2	5,089	2
Fixed Assets	7	28,446	29,839	24,693
Total non current assets		28,448	34,928	24,695
Total assets		39,577	43,229	38,940
LIABILITIES				
Current Liabilities				
Bank overdraft (secured)	8	-	-	-
Payables and accruals	9	6,043	8,950	9,272
Employee entitlements	10	2,712	3,455	2,879
Current Portion of term loans	11	-	-	11,195
Patient & Restricted Trust Funds	14	6	60	72
Total current liabilities		8,761	12,465	23,418
Non Current Liabilities				
Employee entitlements	10	2,231	2,297	2,309
Term loans	11	13,695	11,195	-
Total non current liabilities		15,926	13,492	2,309
Total liabilities		24,687	25,957	25,727
NET ASSETS		14,890	17,272	13,213

For and on behalf of the Board

Gregor D. Coster

Charlie E Robertson

Chairman
20 October 2006

Deputy Chair
20 October 2006

The accompanying statement of accounting policies on pages 16 to 18, and notes on pages 23 to 31 form part of these financial statements.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Budget June 2006 $000	Actual June 2006 $000	Actual June 2005 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MoH, patients and other revenue		92,542	96,786	83,271
Interest received		275	692	576
		92,817	97,478	83,847
Cash was disbursed to:				
Payments to suppliers		50,939	51,787	46,035
Payments to employees		36,897	36,846	33,094
Interest paid		940	792	560
GST (net)		(2)	(194)	206
Capital charge		1,600	1,167	2,256
		90,374	90,398	82,151
Net cash (outflow) / inflow from operating activities	12	2,443	7,080	1,696
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of fixed assets		-	18	-
		-	18	-
Cash was applied to:				
Increase in investments		-	5,087	-
Purchase of fixed assets		6,086	3,638	1,754
		6,086	8,725	1,754
Net cash (outflow) / inflow from investing activities		(6,086)	(8,707)	(1,754)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds of capital injection		1,000	-	1,000
Proceeds from debt financing		2,500	11,195	11,195
		3,500	11,195	12,195
Cash was applied to:				
Repayment of loans		-	11,195	11,327
		-	11,195	11,327
Net cash (outflow) / Inflow from financing activities		3,500	-	868
Net increase/(decrease) in cash held		(143)	(1,627)	810
Add opening cash		3,516	7,072	6,262
CLOSING CASH BALANCE		3,373	5,445	7,072
Made up of:				
Cash and Short Term Investments		3,373	5,445	7,072
CLOSING CASH BALANCE		3,373	5,445	7,072

The accompanying statement of accounting policies on pages 16 to 18, and notes on pages 23 to 31 form part of these financial statements

STATEMENT OF CONTINGENT LIABILITES

AS AT 30 JUNE 2006

	June 2006 $000	June 2005 $000
Personal grievances	20	150
Other Contingent Liabilities	3,600	-

The West Coast District Health Board is currently involved in employment related claims. The Board's best estimates of the potential liability arising from the claims maybe in the amount of $20k.

The West Coast District Health Board is a participating employer in a Defined Benefit Superannuation Plan. If other participating employers were to withdraw the West Coast District Health Board could be liable for funding the plan deficit.

STATEMENT OF COMMITMENTS

AS AT 30 JUNE 2006

	June 2006 $000	June 2005 $000
Capital commitments approved and contracted	300	2,299
Non-cancellable operating lease commitments		
Less than one year	448	536
One to two years	409	537
Two to five years	358	1,610
	1,515	4,982

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 2006 $000	June 2005 $000
Not later than one year	3,848	3,094
Later than one year and not later than two years	2,849	2,614
Later than two years and not later than five years	56	2,572
	6,753	8,280
Total commitments	8,268	13,262

Note 1 : Operating surplus/(deficit)

		June 2006 $000	June 2005 $000
After charging:			
Remuneration of auditor- Audit Fees		84	53
	- Other Services	-	8
Depreciation	- Buildings	408	404
	- Plant and equipment	2,182	2,172
	- Motor vehicles	17	39
Total depreciation charge for year		2,607	2,615
Write down revaluation of fixed assets		-	-
Board Members' remuneration		167	164
Interest expense	- Term Loans (including bank overdraft)	717	744
	- Finance Leases	-	5
Donations		1	1
Rental and Operating lease costs		486	379
Bad debts written off		17	23
Changes in provision for bad debts		8	5
Loss on disposal of assets		24	55
After crediting:			
Interest income		864	584
Donations and bequests		10	25
Gain on sale of assets		21	-

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 2006 $000	June 2005 $000
Opening Balance	44,147	43,147
Equity received during the year	-	1,000
Crown Equity as at 30 June	44,147	44,147

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

	June 2006 $000	June 2005 $000
Retained earnings as at 1 July	(39,527)	(37,853)
Operating (deficit)	(157)	(1,676)
Transfer to Trust Funds (note 3 (c))	-	-
Transfer from Trust Funds (note 3 (c))	1	2
Retained earnings as at 30 June	(39,683)	(39,527)

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 2006 $000	June 2005 $000
Opening Balance	41	43
Transfer from retained earnings in respect of:		
Funds received	-	-
Interest received	-	-
Transfer to retained earnings: in respect of funds spent	(1)	(2)
Trust funds at 30 June	40	41

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

	June 2006 $000	June 2005 $000
Opening Balance	8,552	8,543
Increase in Asset Revaluation Reserve	4,216	9
Asset Revaluation Reserve as at 30 June	12,768	8,552

Note 4 : Receivables and prepayments

	June 2006 $000	June 2005 $000
Trade debtors	1,209	1,055
Provision for doubtful debts	(69)	(61)
	1,140	994
Accrued income	626	5,020
Prepayments	165	285
Total receivables and prepayments	1,931	6,299

Note 5 : Inventories

	June 2006 $000	June 2005 $000
Pharmaceuticals	143	157
Surgical and medical supplies	341	336
Other supplies	117	104
Total inventories	601	597

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

Note 6 : Investments

	June 2006 $000	June 2005 $000
SISSAL	2	2
Term Deposits	5,087	-
Total investments	5,089	2

West Coast DHB has a 4% share in SISSAL (South Island Shared Services Limited) (2005: 4%) West Coast DHB has funds invested in term deposits maturing 31 October 2007 (7.62%) and 1 November 2010 (7.79%).

Note 7 : Fixed assets

	June 2006 $000	June 2005 $000
Freehold land - at valuation	3,675	1,576
Freehold buildings - at cost and valuation	9,106	9,123
Accumulated depreciation	(37)	(861)
Freehold buildings - net book value	9,069	8,262
Buildings Fitout - at cost and valuation	9,703	11,271
Accumulated depreciation	(4)	(2,093)
Buildings Fitout - net book value	9,699	9,178
Equipment - at cost	12,500	11,872
Accumulated depreciation	(7,701)	(7,050)
Equipment - net book value	4,799	4,822
Motor Vehicles - at cost	305	639
Accumulated depreciation	(155)	(584)
Motor Vehicles - net book value	150	55
Computers - at cost	5,036	3,862
Accumulated depreciation	(3,590)	(3,436)
Computers - net book value	1,446	426
Capital work in progress	1,001	374
	1,001	374
Total fixed assets at cost and valuation	41,326	38,717
Accumulated depreciation	(11,487)	(14,024)
Net book value of fixed assets	29,839	24,693

Land and Buildings

Freehold land, buildings and fitout were revalued under FRS3, as at 30 June 2006, by Coast Valuations (Registered Valuers). Buller, Reefton and Grey Hospitals are stated at optimised depreciated replacement cost. Remaining core assets are stated at fair value (market based) and properties intended for sale are stated at the lower of cost and net realisable value. The resulting increase in land, buildings and fitout has been recognised in equity in an Asset Revaluation Reserve (refer to note 3(d)).

The economic life of the Grey Hospital's structure assets has been revised by Coast Valuations from 60 years (in the June 2003 revaluation) to 50 years as at June 2006. The impact of this change in economic life reduces the optimised depreciated replacement cost of these assets by $1,365,000, compared to using an economic life of 60 years.

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 2006 totalled $3,690,000 and the interest rate on the overdraft was 7.685% per annum.

Note 9 : Payables and accruals

	June 2006 $000	June 2005 $000
Trade creditors and accruals	6,227	6,751
Revenue in Advance	619	563
Capital charges due to the Crown	185	246
GST payable	465	271
Payroll Accruals	1,454	1,441
Total payable and accruals	8,950	9,272

Note 10 : Employee entitlements

	June 2006 $000	June 2005 $000
Retiring gratuities	2,407	2,209
Long service leave	275	287
Annual leave	2,669	2,146
Nurses leave (shift)	160	149
Medical education leave	241	397
	5,752	5,188
Made up of:		
Current		
Retiring gratuities	350	298
Long service leave	35	21
Annual leave	2,669	2,146
Nurses leave (shift)	160	149
Medical education and sabbatical leave	241	265
Others	-	-
	3,455	2,879
Non-current	2,297	2,309

Note 11 : Term loans

	June 2006 $000	June 2005 $000
Crown Health Finance Agency (CHFA)	11,195	11,195
Total	11,195	11,195
Less current portion	-	11,195
Non current portion	11,195	-
Interest Rate Summary:		
CHFA	6.11-6.31%	6.72%
Repayable as follows:		
Within one year	-	11,195
One to two years	3,500	-
four to five years	7,695	-
	11,195	11,195

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 2006 $000	June 2005 $000
Net surplus/(deficit)	(157)	(1,676)
Add back non-cash items:		
Depreciation	2,607	2,615
Total non-cash items	2,607	2,615
Adjust for items not classified as operating activities:		
Net(gain)/loss on disposal of fixed assets	3	55
Non operating activities-net	3	55
Add/(less) movements in working capital items		
(Increase)/decrease in receivable and prepayments	4,367	259
(Increase)/decrease in inventories	(4)	(19)
Increase/(decrease) in employee provisions	561	401
Increase/(decrease) in payables and accruals	(297)	61
Working capital movement - net	4,627	702
Net cash inflow/(outflow) from operating activities	7,080	1,696

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.

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 34% (2005:87%) 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 2006 $000	June 2005 $000
Opening balance patients deposits	66	154
Monies received	12	29
Interest earned	4	7
Payments made	(28)	(124)
Closing Balance	54	66

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

	June 2006 $000	June 2005 $000
Opening balance restricted trust funds	6	6
Monies Received	-	-
Interest earned	-	-
Payments made	-	-
Closing Balance	6	6
Total Patient Funds and Restricted Trust Funds	60	72

Note 15: Post balance date events

The Board is aware of the following post balance date events:

Reefton Medical Centre Ltd (sole GP practice in Reefton) was purchased by the WCDHB now trading as Reefton Medical Centre from 31 July 2006.

The iSOFT Patient Management system "went live" 1 July 2006. The cost of this is included in Work in Progress (Note 7) as at 30 June 2006.

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 2006 was 8% (2005: 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 $85,960,654 from the Ministry of Health to fund the provision of health services to the West Coast area in the 12 months ended 30 June 2006 (2005: $76,264,000).

The amount due at year end was $625,457 (2005: $5,288,180). In January 2006 the WCDHB received "early payment" and is now funded in the month services are provided (previously funding was partially paid in the following month).

(b) Key management and Board Members

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

Malcolm Stuart (employed as Head of Department, Anaesthesia).
Carol Atmore (employed as a General Practitioner and GP Liaison Officer).
Glenys Baldick (employed as acting CEO from March 2005 to the end of July 2005).
Robyne Bryant (employed as a Midwife on a part time basis).
Remuneration for these activities is consistent with expertise involved.

Board member Julie Kilkelly is a trustee of the West Coast PHO Board. The West Coast DHB provides funding to and receives funding from, the West Coast PHO for primary medical services. For the year ended 30 June 2006, the West Coast DHB made payments to the West Coast PHO totalling $3,366,553 (2005:$2,663,043) and received funding of $1,093,338 (2005: $780,557).

Julie Kilkelly is a director of Olsen's Pharmacy. 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 2006 amounted to 21% (2005: 21%) of the DHB Funders total pharmaceutical expenditure.

During the year Robyne Bryant was 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. Payment to Coast Care Trust to 30 June 2006 amounted to 100% (2005: 100%) of the DHB Funders total expenditure on community activity programmes.

(c) Other related parties	**Year ended 30 June 2006** $000	**Year ended 30 June 2005** $000
South Island Shared Services Limited (SISSAL)	239	163

Note 18 : FINANCIAL PERFORMANCE INDICATORS

Indicator	Year ended 30 June 2006	Year ended 30 June 2005
Earnings / Net funds employed - %	-0.9%	-12.7%
Debt to debt plus equity - %	39.3%	45.9%
Working capital / Revenue - %	-4.5%	-11.2%
Revenue / Fixed assets - times	3.12	3.37
Interest cover - times	4.42	2.25
Earnings / Revenue - %	-0.2%	-2.0%
Revenue / FTE's - $	153,641	139,788

The West Coast DHB Primary Integration Systems Management Project (PrISM) was highly commended in the Large Innovation category of the New Zealand Health Innovation Awards held on 29 June 2006.

Pictured – Tom Flannagan, Desktop Support Officer (lead support), who linked PrISM from Karamea to Fox Glacier.

OTHER FINANCIAL DISCLOSURES

REMUNERATION

Remuneration paid to Board and Advisory Committee members for the year ended 30 June 2006.

	Board	Advisory Committee	Total
G Coster (Chairman)	30,000	1,500	31,500
C Robertson (Deputy Chair)	18,750	3,312	22,062
R Bryant	15,000	1,250	16,250
J Kilkelly	15,000	1,813	16,813
M Shahadat	15,000	2,937	17,937
M Stuart	15,000	-	15,000
J Vaile	15,000	2,188	17,188
B Wilkinson	15,000	2,250	17,250
C Atmore	15,000	2,000	17,000
G Baldick (Acting CEO July 05)	13,750	1,250	15,000
E Stratford (DSAC)		2,500	2,500
B Greer (CPHAC)		1,250	1,250
K Cannan (HAC)		2,500	2,500
S Ransom (CPHAC)		3,000	3,000
R Wallace (HAC)		2,000	2,000
B Beckford (CPHAC, HAC)		4,500	4,500
G Hammond (DSAC)		2,250	2,250
M Frankpitt (DSAC)		2,250	2,250
E Rock (HAC)		2,250	2,250
P Nolan (DSAC)		2,500	2,500
N Tauwhare (DSAC)		1,250	1,250
	167,500	44,750	212,249

DSAC Disability Services Advisory Committee
CPHAC Community & Public Health Advisory Committee
HAC Hospital Advisory Committee

INSURANCE

Directors and Officers Liability insurance and letters of indemnity have been arranged which cover the actions of Board 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	3
110,001 - 120,000	3
120,001 - 130,000	4
130,001 - 140,000	1
150,001 - 160,000	1
160,001 - 170,000	1
180,001 - 190,000	1
190.001 - 200,000	1
200,001 - 210,000	4
220,001 - 230,000	2
240,001 - 250,000	2
250,001 - 260,000	3
280,001 - 290,000	1
300,001 - 310,000	1
310,001 - 320,000	1
490,001 - 500,000	1

Thirty 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 and backpay.

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

Of the thirty employees shown, twenty six are or were medical employees and four 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 forty four, compared with the actual number of employees of thirty. Eleven of these additional employees are medical staff and three are not.

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 2006 the Board made payments totalling $226,733 to three former employees. The amounts paid were $58,432, $65,000, $103,301.

BOARD MEMBERS' INTEREST

The following items were entered in the interests register for the Board members as at 30 June 2006.

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 SUBCOMMITTEE

Committee Members: Mohammed Shahadat (Chairman), Gregor Coster, 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 2006

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 30/6/06	Actual Performance to 30/6/06
Priority – Improve Maori Health and Implementing He Korowai Oranga		
Increase Investment In Maori Health	• Target for 05/06 year (dependent on discussion with Ministry of funding formula) is to again increase spend on Maori health by 5%. Targets for 06/07 and 07/08 will be for further 5% increases respectively.	• The WCDHB did not meet its target to increase Māori health spending to 5% for 2005/06 as a consequence of the fiscal constraints encountered during the year. Actual funding was increased by 2.75 %. It is still planned to achieve the 5% target set for 06/07.
Increase Maori participation in decision-making	• Engaging with Mana Whenua and other Maori communities to enable them to influence planning, purchasing and delivery of services to build Maori health. • Use He Korowai Oranga, Whakatataka and West Coast DHB's Maori Health Plan 2003-2006/Te Kaupapa Hauora Maori 2003-2006 as the guides for ongoing planning and direction of Maori health development on Tai Poutini. • Review and renew all Memoranda of Understanding. • HKO-01 Maori engagement in decision-making, strategies and plans.	• The CEO, GM Māori Health, and GM Planning and Funding continue to meet with Tatau Pounamu / Māori Health Advisory Committee every 6 weeks. • This occurred during 2005/2006. • After consulting with Manawhenua, Tatau Pounamu Terms of Reference have been established and work regarding a MOU is underway. • Tatau Pounamu members have attended the Māori/DHB governance advisory skills programme 'Te Manu Whakahiato' that was facilitated in Christchurch during April and May 2006. • There is Māori participation/representation within all WCDHB advisory committees at this stage.
To increase the capacity and capability of Maori service providers to deliver effective health and disability services for Maori	• Work with the West Coast PHO and Rata Te Awhina Trust to work effectively together to support initiatives that positively contribute to whanau ora. • The West Coast DHB will share and expand on existing best practice guidelines for clinicians to ensure the clinical and cultural competence of Maori provider services for their clients. • Identify and develop relationships with other Maori community-based health initiatives. • HKO-02 Progress in the development of Maori workforce and Maori providers.	• A new contract has been negotiated with Rata Te Awhina Trust (RTAT) that better reflects a whānau ora model of service delivery. We anticipate close collaboration between Rata and WCDHB to ensure quality services based on the Whanau Ora model are delivered to Māori communities on the West Coast in future. • The WCDHB continues to work on the Tai Poutini Primary Integrated Systems Management (PrISM) Project to enable this to be available to Rata. Both parties have agreed in principle to contract the terms of this project subject to the finalisation of any legal documentation. • During the year, the WCDHB worked with Rata and several other organisations; Community & Public Health, Kawatiri Māori Women's Welfare League, Rongoa Rapana (traditional Māori Rongoa and Mirimiri Massage provider), and He Oranga Pounamu to hold three hui with the Māori community around the West Coast region about diabetes. • The Te Waipounamu Māori Workforce Development Plan 2005-2010 is now completed. Te Herenga Hauora / South Island DHB Māori Managers Network are presently working to develop the position of a Regional Recruitment Specialist for the South Island region to implement

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
		components of the Te Waipounamu Māori Health Workforce Plan 2005-2010. • Te Waipounamu Māori Health Training and Education Opportunities are now completed. A handbook and compact disk have been distributed to the forty-three Te Waipounamu Māori health providers. • Regular discussions held with Rata regarding initiatives that will enhance Māori health. A particular focus will be to hold regular informative hui with West Coast Māori communities regarding chronic diseases.
Encourage initiatives across sectors that positively affect Whanau ora	• Development of a new Intersectoral forum to advance Maori health. • Forum is established by July 05 and West Coast DHB attends at least 90% of meetings.	• An Intersectoral Forum has been established with assistance from the Māori Health Unit. There is participation within this forum by Papatipu Runanga; Te Runanga O Ngati Wae Wae and Te Runanga O Makaawhio. • The WCDHB CEO is a member of a national group that is currently working on initiatives pertaining to Māori health. This group includes CEOs and Māori managers from various DHBs nationwide. • The Maata Waka community have two representatives within Tatau Pounamu / Māori Health Advisory Committee. This provides Maata Waka representation from the Buller and Greymouth districts.
Enhance mainstream service effectiveness	• Implementation of the West Coast DHB's Maori Health Plan 2003-2006/Te Kaupapa Hauora Maori 2003-2006. • Continued progress on welcoming environments for Maori clients.	• Te Pikorua Bi-cultural Training continues to be available to staff. There have been several programmes delivered this year with more planned for Greymouth by the end of the 2006 year. Feedback and evaluations show this training is well received by staff, and provides the opportunity to gain a better knowledge and understanding of Māori views, values and customs.
	• Tikanga Best Practice training to mainstream staff.	• A Tikanga Best Practice programme specifically aimed at nurses is currently delivered to WCDHB nursing staff. This training is an overview of the Tikanga Recommended Best Practice Flipcharts developed for clinical staff in February 2006. Work will continue to ensure Tikanga Best Practice flipcharts are displayed in clinical environments such as WCDHB facilities, GP practices, rest homes etc.
	• Review of care pathways for Maori.	• A 0.5FTE Kaiawhina / Support Worker continues to work at Grey Base Hospital to support patients who identify as Māori. An information brochure has been developed for patients and whanau that explains about the services available i.e. support when accessing services and appointments, accommodation bookings at the Whanau House, assistance with the complaints procedure, access to Health and Disability Code of Rights and Advocacy information etc. A Client Satisfaction Survey of this service is underway and results will be collated in 6-months time.
	• HKO-03 Improving mainstream effectiveness.	• Te Awatea / Cultural Awareness Training Programme is a mandatory cultural awareness programme specifically designed to meet the needs of Social Workers, Fieldworkers, and Home-Based

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
		Support Workers of the WCDHB.
Develop Maori health workforce	• Implementation of the West Coast Maori Workforce Plan.	• The Te Waipounamu Māori Workforce Development Plan 2005-2010 is completed. Te Herenga Hauora / South Island DHB Māori Managers Network are now working to develop the position of a Regional Recruitment Specialist for the Te Waipounamu region. The purpose of this role is to implement components of the Te Waipounamu Māori Health Workforce Plan 2005-2010.
	• Retention through competent cultural support for Maori staff. • HKO-02 Maori Health Workforce.	• A hui for WCDHB Maori staff is held annually. The purpose of these hui is to provide a forum that gives Maori staff the opportunity to share information whether it is clinical or cultural, and to assist and support each other with regard to Tikanga Maori.
Priority - Progressing the NZ Disability Strategy		
Implementation of Disability Strategic Action Plan	• Continue to implement the West Coast DHB's Disability Strategic Action Plan according to the actions specified in the document. • Indicators and targets defined in the Plan.	• Plan has been implemented and continued progress is being monitored. • Some but not all of the indictors and targets have been met during the year.
Priority - Reducing Inequalities		
Inequalities Training is available to staff	• Inequalities training provided by C&PH, and is available to all Board Members, Senior Managers and staff of the WCDHB, and external organisations with whom we have an agreement to share internal training programmes. • RIH-01 Progress towards raising awareness of inequalities and refocussing planning and funding activities to address inequalities in health.	• An Inequalities Training Package has been developed and delivered to the Disability Support Advisory Committee members, Community and Public Health Advisory Committee, Hospital Advisory Committee member, WCDHB Board members, and the Executive Management Team. • In addition a tool has been developed that takes into account the ultimate goal of reducing inequalities when decisions are made around the prioritisation of funding for new positions within the WCDHB.
Priority – Improving Mental Health		
Improve Access For West Coast Residents To Mental Health Services	• Complete the implementation of the rehabilitation support services review to achieve an improved range of rehabilitation residential options for consumers which better meets their needs and also results in reduced length of stay in the sub acute inpatient unit, better crisis respite options, provision of alcohol and drug residential beds and an improved more focused rehabilitation service. • Continue to monitor access to specialist regional mental health services in other centres for West Coast residents. • Continue to monitor access of West Coast residents to Mental Health services on the West Coast. • Implement recommendations of the cross sectoral service development group for Alcohol and Other Drug services focusing on improved dual	• Reconfiguration has not yet been completed due to external delays in commencing the development of self contained units. An interim arrangement is in place to provide services for a limited number of Level IV placements and additional respite care options. Active engagement continues between all project stakeholders. • Access to regional mental health services continues to be monitored. There has been a higher utilisation of these services in the past year. • Access to West Coast based mental health services continues at a high level. Data issues over the past year have now been resolved so more accurate information on access rates over the past 12 months will be available. • Recommendations in relation to the Alcohol and Other Drug Service Development Group have not yet been implemented as there has been a delay in establishing the cross sectoral group. This project is

<table>
<tr><th>Output</th><th>Performance Target to 30/6/06</th><th>Actual Performance to 30/6/06</th></tr>
<tr><td></td><td>diagnosis management, models of treatment, closer integration with primary services and implementing recommendations from Regional Alcohol and Other Drug review.
• POP-08 Improving the health status of people with severe mental illness.
• 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>
<tr><td>Older People</td><td>1.75%</td><td>1.75%</td><td>1.75%</td></tr>
</table></td><td>now scheduled to commence in September 2006.
• Information and reporting systems within the Mental Health Service are currently being upgraded so accurate information on numbers of clients enrolled with a GP is not yet available.</td></tr>
<tr><td>Improve the physical health status of people with a serious mental illness</td><td>• Improve the physical health status of the 3% of the population with a severe mental illness.
• Ascertain the level of co-morbidity for current service users, using the Knowing the People Planning Project (KPP).
• Monitor the number of long term clients accessing regular physical health checks through the KPP Project.
• Roll out Primary Health Link programme [joint Work and Income NZ/WCDHB] to all primary practices to reduce financial barrier to MH consumers to accessing primary health services.
• Educate and encourage service users to have regular physical health checks and screenings for lifestyle or predisposing factors, as a way to prevent serious physical illness.
• Investigate the introduction of free Influenza vaccinations for individuals with Serious Mental Illness, who are not eligible through current schemes.
• Investigate the development of targeted health promotion programmes for people with serious mental illness.
• 95% of clients of the MHS are linked to an appropriate primary care provider by June 2006.</td><td>• Knowing the People Planning continues to monitor long term clients their health needs.
• Primary Health Link has been rolled out to 90% of practices on the West Coast improving access to GP services for about 30% of long term clients.
• Service users are encouraged to improve their physical health through discussion with case managers, development of programmes to remove barriers to accessing primary health services and encouragement of healthy eating and healthy activity.
• Planning will commence shortly for the next stage in development of targeted health promotion programmes for people with serious mental illness.
• With the establishment of Primary Health Link across the region long term service users are better able to access GP care with removal of the cost barrier and we are close to achieving the 95% of clients linked to a primary health provider target.</td></tr>
<tr><td>Ensure Successful Treatment Outcomes For Consumers</td><td>• Complete the implementation of the MH SMART project within the WCDHB ensuring that the capacity for the continuing collection and assessment of outcome measurements is sustainable. Review possibilities for implementation within NGOs.</td><td>• The MH SMART programme has been implemented and data to inform individual and service planning is now available from the first collections of information. The Ministry of Health is to fund a programme to integrate MHINC and MH SMART data and to roll out collection to NGOs.</td></tr>
</table>

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	• Implement a standardised measure of consumer feedback within the mental health sector and provide a feedback loop between service users and service providers. • Support training in recovery for clinical and support staff across the sector. • Continue to support the Knowing the People Planning approach to managing services for consumers who are high users of services and provide support for the MHS and NGOs to develop, alongside service users, an integrated single recovery plan. • POP-08 Progress towards improving mental health. • SER-05 Improving service responsiveness.	• A national consumer feedback survey has been piloted and is to be rolled out across NZ. Limited responses were received from West Coast service users and we will work with consumer representatives to try to improve the response rate. • Recovery underpins our service provision framework and training is provided.
Improve Maori Mental Health Services	• Implement and review the Maori Mental Health Strategic Plan focussing on improving services for Clients/Tangata Whaiora. It includes a focus on achieving improved access for consumers to the service, measuring and achieving consumer satisfaction with services received, a service delivery plan which includes cultural assessment and treatment processes, a Tikanga Maori plan and a workforce development strategy. • In addition, the West Coast is participating in the regional services project around improving accessibility, quality and consistency of Kaupapa Maori services in the South Island. A local advisory group is in place and monitors service development. • Ongoing audit of mental health services against Standard One of the National Mental Health Standards will indicate areas for improvement, which will be addressed. • The tangata whaiora network continues to gain strength and is involved in providing feedback on service development and service provision. • Aim to increase the number of Maori staff working in mental health services. • Maintain current resourcing levels for the Maori mental health service which currently exceeds benchmark levels, and improve the linkages between the MMH service and mainstream services to ensure access for Maori to a culturally appropriate service whether mainstream or Kaupapa Maori. • POP-08 Improving the health status of people with severe mental illness.	• Service improvements continue to be implemented. Tikanga Maori has been implemented across the DHB. Cultural assessment tools are available. • We continue to participate in the regional Kaupapa Maori project. • Tangata Whaiora support network continues with a Maori consumer advisor leading a tangata whaiora group. Service changes are proposed for this year which will further enhance peer support and advocacy services for all consumers including tangata whaiora. • We continue to aim to improve the number of Maori working in Mental Health services. Current Maori Mental Health resourcing levels have been maintained.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
Workforce Development Is Prioritised	• Key issues relate to the recruitment and retention of key specialist personnel including psychiatrists, nurses and allied health staff. • Relationships with other DHBs will be strengthened as part of regional networking. Access is being sought to generic training programmes of larger DHBs and regional initiatives are in place in relation to training around shared care, family/whanau integration into the recovery process, cultural training and the mental health Strengths model. • West Coast is participating as one of the priority pilot training areas for specialist training for child and adolescent mental health staff run by the University of Auckland. • Access to DHB training is made available to NGOs. • Education needs of the consumer workforce are addressed. • Increased numbers of Maori staff are achieved to ensure representation of Maori in local mental health workforce. • Good employer policies will be followed to encourage retention of skilled workforce. • Workforce development committee is established and will prioritise programme. • Staff turnover does not exceed a level to be determined.	• Recruitment to key positions has been successful and turnover has been relatively low during the past year. • Individual training needs for staff identified, service priorities and best practice guidelines have been developed. • Workforce development committee ongoing. • Collaboration with NGOs is achieved with NGOs able to access our training programmes. • Training has been provided to consumers on peer support, interview training and other topics. • Not yet implemented. • The workforce development committee has been established.
Collaboration with other agencies to achieve continuum of care and integrated multi sector approach to comprehensive care	• Continue to Improve linkages with housing and employment agencies to improve recovery pathways of consumers. • Continue involvement with Strengthening Families programme. • Work with PHO to ensure primary health practitioners are trained in primary health care guidelines and available to mental health consumers through shared care initiatives. • Implement the Primary Mental Health plan. • Regularly review memoranda of understanding with police and with NGOs to ensure relationships are maintained and issues resolved. • Ensure an effective case management approach is in place which ensure care is coordinated when consumers are receiving services from more than one agency.	• Agreements with VCT and NGOs have been signed to facilitate employment, supported accommodation and activity. • Involvement with and participation in Strengthening Families continues. • Primary mental plan implementation continues with the funding of the PHO to employ staff to provide liaison and education support for primary practitioners working with people with mild to moderate mental health issues and also to provide brief intervention treatment sessions. • Care for service users is coordinated when they are receiving services from more than one agency. The development of the Level IV placements has been based on protocols being developed between the DHB provider arm and NGOs contracted to provide residential and activities support so the input from each agency is integrated into a single plan.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
Improve Mental Health Information Collection	• Recognise the importance of accurate data collection in underpinning future service planning. • Comply with diagnosis reporting requirements to meet required timeframe. • Ensure reports are disseminated among key staff and are used to guide resource allocation decisions and are seen to be useful, thereby improving accuracy. • Provide support to NGOs as necessary to encourage MHINC reporting. • Comprehensive, accurate and timely data is provided to MHINC.	• While having been unable for much of the past year to report MH diagnosis data as required by the MOH we have now improved our information systems and have commenced reporting this and all other MHINC data as required. • A significant focus for us is improving data quality and integrating this information with outcome data provided by MH SMART. • Reporting of accurate data to staff has commenced and is leading to significant changes in the way services are best targeted to meet highest need. • We intend to work with NGOs this year to ascertain capacity for beginning MHINC and MH SMART data collection.
Effective Engagement With Other DHBs and with Consumers	• The West Coast is committed to regional cooperation with other DHBs, in particular in the South Island, through the regional mental health network. As a small DHB, we must have effective understandings with larger DHBs for support in the provision of a range of services. • Mental Health Quality Measures.	• Participation continues in South Island Regional Mental Health Network and in regional mental health service planning. • There is active engagement with family and consumer representatives in service planning. • Because of regional collaboration providing access to regional services, as a small DHB we are able to provide a full range of mental health services to our population safely and effectively.
Priority - Suicide Prevention		
Reduce the rate of suicides and suicide attempts – on the West Coast	• Work collaboratively with CPH to implement the youth suicide prevention programme. • Review and widen the non-accidental injury data being collected by CPH from Grey Hospital to other DHB services. • Facilitate skill training among primary providers, mental health professionals, emergency department staff and community organisation staff and encourage use of MOH suicide prevention guidelines. • Through CPH support Youthline and the development of a sustainable infrastructure for that organisation. • Participate in inter sectoral initiatives to prevent suicide. • Continue to implement and monitor guidelines for emergency department and mental health services in managing people at risk of suicide. • Progress in developing the capacity of primary care providers to impact on suicide prevention.	• The West Coast is participating in a suicide prevention collaborative which aims to improve service and individual responses to people who have attempted self harm or attempted suicide. • There has been limited progress this year in facilitating skill training among primary health practitioners or engaging in inter sectoral suicide prevention work due to a lack of available resource. We propose to prioritise this work in the next year.
Priority - Primary Mental Health		
To Meet The Needs Of The 17% Of The Population With Diagnosable Mental Heath	• Implement the Primary Mental Health Plan: • Establish Access West Coast by July 2005 [DHB/PHO] to coordinate primary mental health service development.	• GPs routinely monitor the physical health status of patients with a diagnosable mental illness. • Primary practices are encouraged to enrol eligible

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
Disorders	• Fund GP Liaison Coordinator and Brief intervention Service as agreed with MOH. • Facilitate improved access to primary care through the GP Link programme to remove financial barriers to access. • Facilitate improved training and education for primary health workers in mental health issues through Access west Coast and through the GP Liaison position. • Review current access to family counselling services on the West Coast and lead the coordination of services to ensure improved access. • Work with local mental health promotion service to promote improved access and targeting. • Develop shared care programmes between MHS and primary care workers to facilitate recovery. • Investigate the establishment of peer support and support group services. • Improve the physical health status of people with a mild to moderate mental illness presenting to primary health services. • Educate the community (including primary care providers and service users) about the importance of regular physical health cheeks for individuals with a diagnosed mental illness Encourage primary practitioners to routinely screen all patients with a diagnosed mental illness for physical illnesses. • Encourage primary practitioners to regularly assess patients with a diagnosed mental illness for lifestyle or predisposing factors, as a way to prevent serious physical illness. • Routine physical health screening and lifestyle advice is provided for all patients with a diagnosed mental illness by primary health practitioners. • GP Liaison position effective in providing support for primary health workers. • Brief intervention programme in place and feedback/outcome measurement indicates acceptability and effectiveness.	people in Careplus and GP Link for people with a diagnosed mental illness as this includes a requirement for regular physical health screening. • Access West Coast not yet in place but prioritised for next year. • GP Liaison Coordinator and Brief intervention Service funded and established and an agreed evaluation process is underway. • Primary Health Link [GP Link] now available in 90% of practices across the West Coast. • Access to improved training and education for primary health workers in mental health issues facilitated through the GP Liaison position. • Development of a shared care protocol has commenced. • Peer support programme has been developed, consulted on and is about to be implemented.
Improve Access For People With Mild To Moderate Mental Health Issues To Primary Mental Health Care On The West Coast	• Implement Primary Health Link programme to reduce cost to Mental Health clients of accessing GP services. • Ensure uptake of Care Plus (Priority Patient Funding) for mental health clients, where eligible, again reducing cost to the client. • Encourage cross sectoral participation in Intermediate Training level	• Primary Health Link programme available in all GP practices. • Improving uptake of Care Plus programme by people with mental health problems. • Increased provision over past year of Methadone services by GPs.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	programmes in Shared Care. • Evaluate the benefits of locating Methadone clinics in GP surgeries (improving access and reducing stigma). • Care Plus uptake monitored. • Primary Health Link implementation evaluated.	• Evaluation of Primary Health Link will continue and be formalised when roll out is complete.
Priority - Disability and Older People		
A Plan to Implement an Integrated Continuum of Care	• Establishment of PAG in 2003-04. Continuation of this group to oversee implementation and further development of the Plan as necessary. • Merge NASC and short term needs assessment and service coordination functions thus accepting all referrals through one coordinating centre. • Commence the development of packages of care for easily defined conditions. • Better coordinate service delivery for older persons within the DHB. • **POP-13 Ambulatory Sensitive Admissions** - Older People - Discharge rate per 1000 population. Data for this measure is supplied through the Ministry of Health by ethnicity. • **POP-14 Residential Care/Home Care.** Targets for this measure need to be clarified and agreed when baseline data becomes available through Ministry of Health monitoring and reporting arrangements.	• The NASC plan to centralise in a Coordinating centre by August 2005 was not achieved. As a consequence plans to have packages of care developed by July 2005 and then progressively implemented – was also not achieved. • The structure of Older Persons service management within the DHB will now be reconfigured during 2006/07. • **POP-13** – **Achieved.** West Coast rates do not vary significantly from the overall national rates at the 99% confidence interval. • **POP-14** – Not measured in 2005/06. Baseline data still to be defined by the Ministry of Health.
Realign service delivery for older people with funding and provision of an integrated continuum of care	• Review current levels of service provision for older people: home based support services [personal care, domestic assistance, carer support] and residential care [rest home, dementia and hospital level care]. • Develop a funding plan to ensure service levels meet ICC objectives and provide equitable access within available funds. • Utilise improved information sources including coordinating centre information, to determine most effective way of providing health and support services and maintain optimum independence. • Analyse current utilisation of residential accommodation and investigate and implement community based alternatives [Ageing in Place]. • Consider and adopt if appropriate recommendations from the study commissioned by Buller District Council. • Budgets are established and are not	• Achievement of these objectives is still underway but not due for completion before the end of the 2006/2007 year.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	exceeded. • Health and independence of older people on the West Coast are at a minimum maintained and preferably optimised.	
Priority - Reducing the Incidence and Impact of Diabetes		
Diabetes Risk Reduction : Reducing Diabetes contributory risk factors	• Modification of lifestyle factors such as obesity and exercise are crucial components to the prevention of diabetes. People with a body mass index (BMI) >25 (especially those with BMI >30) can decrease the risk of diabetes with graduated lifestyle change. • Working with CPH, WCPHO and other providers, to build on work already undertaken to ensure education resources that promote physical activity and healthy eating are readily available and distributed for at-risk and high risk groups, including Maori. • Continue to encourage and promote 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). • Working with local schools to encourage further uptake of the Health Promoting Schools / Healthy Eating Healthy Action ([HEHA) initiative throughout the region. [NOTE: the majority of primary and secondary schools on the West Coast are already currently actively working towards the Health Promoting Schools framework]. • Obesity: the number of Health Promoting Schools as a percentage of the total number of schools within the DHB (as part of the Healthy Eating Healthy Action [HEHA]).	• Roll-out of initiatives aimed at increasing physical activity levels, reducing obesity, and improving nutrition - included the Sea-to-Sea Challenge over a six-week period during October and November 2005 that involved 500 people Coast-wide in physical activity; the implementation of new HEHA polices within DHB premises as a role model for others in the community; ongoing participation in Active West Coast (a collaboration of groups/organisations trying to get more West Coasters more active more often); • Ongoing delivery of the Appetite for Life programme (a 6-week programme designed to assist women Coast-wide with the long-term objective to help them to achieve self-motivated healthy, active lifestyles); and the delivery of the "Spring into Action" Challenge programme. • The "Spring into Action" programme this time involved over 1500 people Coast-wide in physical activity (including over 500 children) over a six-week period for adults/four-week period for children, between May and June 2006. [Our 2005 "Spring Into Action" programme was named as a finalist in the New Zealand Health Innovations awards for 2006. The 2005 programme also saw the West Coast DHB win the award in the large organisation category in the Push Play Activity Friendly Business Awards in December 2005 for best physical activity workplace initiative]. • "Get Checked" screening promotion programme continued to be provided. • The current percentage of registered Health Promoting schools on the West Coast is 2.8% [-just one school (Runanga Primary school) is formally enrolled with the framework]. Public Health Nursing services, with the support of Community and Public Health, were active in working with other schools throughout the West Coast region to encourage the uptake of the Health Promoting schools framework, encouraging healthy schools environments, and HEHA related programmes such as Spring into Action.
Diabetes recognition and follow-up : Increase early recognition and response to individuals with diabetes	**Increase early recognition and response to individuals with diabetes:** • 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	• Information from WCPHO database has yet to be advanced to a stage where it can be regularly shared and used to inform planning initiatives and targeting of service provider activities to best effect diabetes detection and follow-up for annual checks. • The Integrated Diabetes Service Working Party that commenced work in 2005, was itself integrated into the Local Diabetes Team (LDT), with the role of overseeing and contributing to the further enhancement, closer collaboration, and effective delivery of diabetes services on the West Coast.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	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 providers to focus reciprocal referral and service delivery mechanisms to meet the needs of the Maori community to ensure best health care outcomes. • As mentioned above, encourage and promote annual "Get Checked" diabetes screening through the WCPHO, CPH, Maori health and other providers, with referral on to appropriate service provider(s). • Hospitals have a system in place to ensure people admitted (for any reason) who have cardiovascular system and diabetic risk factors receive advice about reducing risk factors, along with referral on to other appropriate health professionals for further follow-up and intervention. • Feedback from Integrated Diabetes Service Working Party to be integral to planning for future local service improvements in diabetes recognition and response to individuals. • **POP-01 Diabetes case detection and Follow-up rate.** **Numerator:** (Data source: DHB) The number of unique individuals with type I or type II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period. **Denominator:** (Data Source: MOH). • The expected number of unique individuals to have type I or type II diabetes mellitus, as at the end of the reporting period.	This group has multi-sectoral representation, including consumers, local Maori, general practitioners, a diabetes nurse educator, a specialist physician, dietician, a local pharmacist, and a WCDHB and WCPHO Board member, and is the cornerstone reference and planning group for overall improved delivery of diabetes services on the West Coast. • The LDT progressed work toward the implementation of the Integrated Diabetes Service Plan (completed by the LDT in April 2005) during early in 2005/06, covering various local approaches toward diabetes awareness promotion, detection and follow-up, and diabetes management. This Plan included work around a patient held record, retinal screening services, patient and provider surveys, shared databases, podiatry service referral protocols, annual pharmacy reviews, exercise and self-management programme, agreed referral guidelines between services, Maori community involvement, and evidence-based directions about diabetes detection. • A dual-focus survey of people with diabetes and of diabetes service providers was prepared and undertaken by the LDT during 2005/06 to learn more about perceived gaps in service delivery. The findings of his survey were presented to the LDT in June 2006 and will be utilised to assist effective planning of improvements that can be made to diabetes services on the West Coast in 2006/07 and beyond. • The LDT has set a primary goal for the West Coast DHB of increasing enrolment and uptake of free annual diabetes checks in 2006 and of seeking improvement in the quality of care delivered in 2007. To this end, the LDT has set goals that the West Coast DHB, West Coast PHO, and other primary services providers to work closely together in: • Working with primary care providers to enhance their ability to provide the free annual diabetes check to their patients. • Supporting primary providers through the offer of assistance and education, provided by DHB staff involved in the direct care and management of people with diabetes. • Working with Rata Te Awhina Trust to encourage and improve Maori uptake of the free annual checks. • Improving quality of data captured – including recording data relating to ethnicity. • Supporting the continuation of a Diabetes Retinal Screening service on the West Coast, and the extension of the eligibility to access to the service to include those people who live in areas not currently covered by the West Coast PHO. • An informative, user-friendly "Beginners Guide to Diabetes" booklet has been developed through the efforts of local nurses Jan Weaver and Norma Devlin. The use of this publication has been endorsed by the LDT as part of a move to

<table>
<tr><th>Output</th><th>Performance Target to 30/6/06</th><th>Actual Performance to 30/6/06</th></tr>
<tr><td></td><td></td><td>encourage better patient self-management practice to allow people to effect better control over their diabetes.
• The LDT has also been working on the development of a patient-held record that will provide ready-to-hand up-to-date information to service providers as people with diabetes interface with different primary and secondary care providers. This record is being developed in tandem with patient self-management care plans that are currently being developed for all chronic conditions as part of the West Coast DHB Chronic Conditions Management work plans.
• The LDT will also work towards implementing aspects of the West Coast Integrated Diabetes Service plan, including the provision of a nutritional and exercise courses, enhanced patient self-management education, and an annual community pharmacy reviews for people with diabetes, as these can be incorporated within available resources.
• Case Detection Rates : Not Achieved. The percentages of people with type I or type II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period (as a percentage of the expected number of unique individuals to have type I or type II diabetes mellitus on the West Coast) during the twelve month period to 31 December 2005 were as follows:

<table>
<tr><th>Case Detection</th><th>Target</th><th>Result</th></tr>
<tr><td>Maori</td><td>50%</td><td>26.0%</td></tr>
<tr><td>Pacific</td><td>50%</td><td>40.8%</td></tr>
<tr><td>All Others</td><td>65%</td><td>60.1%</td></tr>
<tr><td>Total</td><td>63%</td><td>55.2%</td></tr>
</table>

We note that these rates are somewhat under-represented. Data for the numerator for this indicator is drawn from the West Coast PHO database of enrolled patients. It is noted that some 13% of the West Coast population is not currently recorded on this database, as three practices were not part of the PHO in 2005 – nor was their data available for inclusion in the analysis. Data for the denominator includes the expected number for whole of the population for as calculated by the Ministry of Health. Two of the three practices subsequently joined the PHO in early 2006, so that their data should be included in the 2006 calendar year results and future monitoring analysis.</td></tr>
<tr><td>Diabetes Management</td><td>1. Slow rate of diabetes progression, reduce incidence of avoidable diabetes related complications
2. Strengthen self-management capability of individuals, family and whanau.
• Aim to make checks more accessible to population. Trained practice nurses can provide much of the screening process.</td><td>• The LDT set a goal to have at least 63% of known people with diabetes accessing free annual checks (increase from 50% at present) within the next 2 years, with 85% or more of these people having an HBA1c equal to or less than 8%.
• Plans to improve diabetes management have been developed by the LDT during 2005/06 – see commentary on this in the Diabetes Detection and</td></tr>
</table>

<table>
<tr><th>Output</th><th>Performance Target to 30/6/06</th><th>Actual Performance to 30/6/06</th></tr>
<tr><td></td><td>

Free annual checks through the PHO.
As mentioned above, encourage and promote 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).
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.
Feedback from Integrated Diabetes Service Working Party to be integral to planning for future local service improvements in diabetes management for individuals and their families/whanau.
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.
POP-01 Diabetes management:

Numerator: (Data source: DHB)
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% and at their free annual check during the reporting period.

Denominator: (Data Source: DHB).

The number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period.

</td><td>
Follow-up section above.

The percentages of West Coast people with type I or type II diabetes mellitus on a diabetes register that had an HBA1c of equal to or less than 8% at their free annual check during the reporting period (as a percentage of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period) during the twelve month period to 31 December 2005 were as follows:

<table>
<tr><th>Case Management</th><th>Target</th><th>Result</th></tr>
<tr><td>Maori</td><td>85%</td><td>79.4%</td></tr>
<tr><td>Pacific</td><td>85%</td><td>100%</td></tr>
<tr><td>All Others</td><td>85%</td><td>78.9%</td></tr>
<tr><td>Total</td><td>85%</td><td>79.0%</td></tr>
</table>
As noted above, these rates are somewhat under-represented. Data for the numerator for this indicator is drawn from the West Coast PHO database of enrolled patients. It is noted that some 13% of the West Coast population is not currently recorded on this database, as three practices were not part of the PHO in 2005 – nor was their data available for inclusion in the analysis. Two of the three practices subsequently joined the PHO in early 2006, so that their data should be included in the 2006 calendar year results and future monitoring analysis.
</td></tr>
<tr><td>Diabetic Retinopathy Screening</td><td>
Diabetes is the most common cause of avoidable loss of vision of people working age in developed countries. Is reliably detected by screening and there are effective treatments. Our aim for diabetic retinopathy screening is to prevent the development and progression if diabetic eye disease by building upon recent innovations in having a locally available retinal screening service and increasing coordination across providers, processes & community resources.
Improve access to retinopathy screening:

Aim to increase the proportion of people with diabetes accessing photographic retinopathy screening (as indicated through WCPHO annual data).
Feedback from Integrated Diabetes Service Working Party to be integral to planning for future local service

</td><td>

The Diabetic Retinal Screening service continued to be provided in the main centres on the West Coast by HealthLink South, under contract to the WCPHO.
The percentages of West Coast people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years and the date of the free annual check during the twelve month period to 31 December 2005 were as follows:

</td></tr>
</table>

<table>
<tr><th>Output</th><th>Performance Target to 30/6/06</th><th>Actual Performance to 30/6/06</th></tr>
<tr><td></td><td>improvements in diabetic retinal screening for individuals.
• POP-01 Diabetic Retinopathy Screening
Numerator: (Data source: DHB).
The number of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years and the date of the free annual check during the reporting period.

Denominator: (Data Source: DHB).
• The number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period.</td><td><table><tr><th>Retinopathy (Eye) Screening</th><th>Target</th><th>Result</th></tr><tr><td>Maori</td><td>88%</td><td>79.4%</td></tr><tr><td>Pacific</td><td>100%</td><td>100%</td></tr><tr><td>All Others</td><td>88%</td><td>87.9%</td></tr><tr><td>Total</td><td>88%</td><td>87.4%</td></tr></table>• As noted, and for the same reasons outlined above, these rates are somewhat under-represented.</td></tr>
<tr><td colspan="3">Priority - Reducing the Incidence and Impact of Cardiovascular Disease and Stroke</td></tr>
<tr><td>CVD and Stroke Risk Reduction: Reduce CVD contributory risk factors</td><td>Modification of lifestyle factors such as smoking, exercise and obesity are crucial components to the prevention of CVD.
• Establishment of a multi-sector service development group to investigate best practice implementation of the national Cardiovascular Guidelines and a population health approach to CVD risk reduction strategies across health service providers and in the community, within the local context and within available resources.
• Smoke free policies are in place across the DHB premises – enforcement of policies to be enhanced.
• Encourage adoption of smoke-free policies in DHB-funded NGO provider facilities, where such policies are not already in place.
• Active encouragement of modification of lifestyle factors such as smoking, exercise and obesity (including reduction in personal salt and sugar intake) as crucial components to the prevention of CVD through community groups, community events, and activities campaigns.
• Build on work already undertaken with CPH, WCPHO, Sport West Coast and Sport Buller, and with other health service providers to promote better health and healthy lifestyles within the West Coast community.
• Build on work already undertaken with CPH, WCPHO and other providers, to ensure education resources that promote physical activity and healthy eating are readily available and distributed for at-risk and high risk groups, including Maori.
• Encouragement of targeted public awareness campaigns undertaken by community groups – for example:</td><td>• Our 2005/06 District Annual Plan identified that the West Coast DHB would embark on several service development and planning group work-streams, (within specified timeframes), around cardiovascular disease, stroke care management, cancer control, respiratory and palliative care services on the West Coast. Further work undertaken since the 2005/06 DAP was completed identified much commonality and many inter-related issues that cut across these various chronic conditions; such that a more holistic and comprehensive approach to planning service improvement and integration was more likely to produce better outcomes than was looking at the individual conditions in isolation. To this end, planning focus shifted to developing a comprehensive Chronic Conditions Care Management work plan that would overarch improving management and best practice principles for services on the West Coast, rather than a series of condition-specific working parties. Work on the Chronic Conditions Care Management strategy commenced in October 2005.
• The Chronic Conditions Care Management Plan was largely completed by June 2005, and is due to be finalized and presented to the DHB Board in early 2006/07 for review and approval. The Plan covers all stages of the health and illness continuum for people with chronic conditions in terms of optimizing a healthy environment; providing for at risk populations; managing the acute event; initial management (first six months) of a chronic condition; and the longer term management (over six months) of a chronic condition. Across each of these five major categories in the continuum, the plan looks toward improvement in the following seven elements over the next three years in the West Coast setting: healthy systems (organization of health care); community resources and policy; delivery system redesign; decision support; clinical information systems; self management; and equity in health including access to and outcomes of health care.
• Implementation of at least two major health promotion projects targeting CVD risk was</td></tr>
</table>

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	support a repeat of the "Men's Only Night" health issues education and promotion sessions run during 2004. • **POP-02 CVD Risk Reduction:** • Narrative update report of activities undertaken in support of CVD risk reduction initiatives.	achieved through the "Sea to Sea" and the "Spring into Action" challenge programmes (See also Diabetes – risk reduction section above). • Healthy eating, healthy activity and healthy lifestyles and health-related public awareness campaigns continued to be actively promoted through CPH, WCPHO, WCDHB, and other providers on the West Coast throughout the year. • All West Coast DHB premises are smokefree environments. • Work has still to be undertaken in contracting to encourage the adoption of smoke-free policies in DHB-funded NGO provider facilities, where such policies are not already in place.
CVD and Stroke recognition and follow-up – Primary Care	Increase early recognition & response to individuals with CVD. Slow rate of CVD progression, reduce incidence of avoidable CVD related complications. • Continue to work towards improving co-ordination between primary and secondary health providers through the GP Liaison and WCPHO, with older people residential services, and with Maori health service providers to help reduce preventable CVD admissions; develop referral guidelines; and encourage utilisation of CVD best practice clinical guidelines. • Information sharing between WCDHB and WCPHO to inform planning initiatives and targeting of service provider activities to best effect CVD risk detection and follow-up checks. • Work through WCPHO to implement a monitored approach to providing primary CVD risk assessments of at-risk people at determined time intervals. CVD risk assessment may be used as a substitute for the stroke risk assessment. • In view of the findings of the 2004/05 West Coast Health Needs Assessment Profile, identify utilisation of cardiovascular services by Maori on the West Coast – in particular, to identify barriers for access, acceptability of mainstream services for Maori, and for improved co-ordination/liaison with Rata Te Awhina Trust services. • Use of educational and promotional opportunities within community groups, community events, and activities campaigns to increase self and family/whanau awareness of the importance of recognition of risk factors and early signs of ischaemic heart disease, and seeking early intervention through primary care and support services. • Feedback from CVD Service Development Group to be integral to planning for future local service	• Improving closer co-ordination between primary and secondary health providers to help reduce preventable CVD admissions; the development of referral guidelines; improved responsiveness to Maori; improved promotion of self and whanau awareness for recognition of CVD risk signs and factors; and encouragement of the utilisation of CVD best practice clinical guidelines; is well underway through the inter-sectoral primary and secondary service involvement in the development of the Chronic Conditions Care Management Plan (see above). This Plan is to be progressively implemented during the next three years. • Active monitoring of recorded 5-year absolute CVD risk not achieved in 2005/06. This action point has been rolled through to the 2006/07 DAP for implementation. • Hospitals do not yet have a system in place to ensure people admitted (for any reason) who have cardiovascular system and other risk factors receive advice about reducing risk factors, along with referral on to other appropriate health professionals for further follow-up and intervention. This action point has been rolled through to the 2006/07 DAP for implementation.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	improvements in CVD risk recognition and response to individuals. • **POP-02 : CVD recognition and follow-up.** **Numerator:** (Data source: DHB via PHO monitoring framework) The number of people in each target group who have had their 5-year absolute CVD risk recorded in the last five years. **Denominator:** (Data Source: DHB via PHO monitoring framework).	
CVD and Stroke Management – secondary care sector.	Management of a 5-year absolute risk of 15 % and above in general is not optimal and requires an increase in both the awareness of these risk factors and the appropriate, evidence based use of existing therapeutic interventions. Lifestyle advice, and aspirin, statin and blood pressure lowering medication reduce cardiovascular events and related complications. Long-term antiplatelet treatment after stroke shows a reduction of non-fatal and serious vascular events. Treatment with a statin after stroke is associated with a reduction of major vascular events including stroke. Blood pressure lowering treatment reduces the risk of recurrent stroke. A comprehensive plan of care covering all aspects of CVD and Stroke is vital to ensure risk reduction. To this end, WCDHB's aim is to: 1. Slow rate of CVD progression, reduce incidence of avoidable CVD and Stroke related complications. 2. Strengthen self-management capability of individuals, family & whanau. • Active promotion, support and encouragement of self-management capability of individuals, family & whanau in their contact with both primary and secondary services. • Feedback from CVD Service Development Group to be integral to planning for future local service improvements in CVD risk management for individuals and their families/whanau. • Investigate the feasibility of the implementation of pre-hospital thrombolysis medication use for emergency response on the West Coast. It is noted that there are cost implications of expensive drugs and GP time and availability that may mitigate against this being introduced. • Provide individually targeted lifestyle advice, and aspirin, statin and blood pressure lowering medication to reduce cardiovascular events and related complications at secondary care services – with such care plan regimes communicated back to GPs to ensure continuity of patient care and effective	• As above, a Chronic Conditions Care Management plan has been developed during 2005/06 that will both inform and drive future local service improvements in CVD risk management for individuals and their families/whanau. This will include General Practices being engaged in the development and management of comprehensive individualised care plans for people at risk of, or have suffered from CVD (and stroke), with support from the WCDHB secondary services as required and inter-sectoral sharing of targeted care plan information. • A feasibility evaluation of the implementation of pre-hospital thrombolysis medication use for emergency response was undertaken by 30 April 2006, but was not progressed any further due to current financial constraints.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	monitoring. • Provide individually targeted lifestyle advice, and long-term antiplatelet treatment, statin and blood pressure lowering medication to reduce stroke related complications at secondary care services – with such care plan regimes communicated back to GPs to ensure continuity of patient care and effective monitoring. • **POP-02 CVD Management.** **Numerator:** (Data source: DHB via PHO monitoring framework). The number of people who have a 5-year absolute CVD risk of 15% and above who have a CV management/care plan which includes patient specific goals and follows best practice guideline advice. **Denominator:** (Data Source: DHB via PHO monitoring framework). The number of people with a 5-year absolute CVD risk of 15% and above.	• Establishment and monitoring of 5-year absolute CVD risk care plan dataset has still to be undertaken.
CVD and Stroke Services	There is strong NZ and overseas evidence that patients with coronary heart disease should be referred to a cardiac rehabilitation programme, except for individual cases excluded on clinical grounds. Special consideration to cardiac rehabilitation programmes for appropriateness and acceptability to Maori and Pacific peoples who are at high risk is important. Rehabilitation, post a cardiac event, is very important to the ongoing minimisation of risk for the individual. WCDHB aims to ensure that cardiac rehabilitation services are co-ordinated across all providers so as to ensure the greatest possible gains for the individual and reduce their risk or follow on CVD events. We aim to increase coordination across providers, processes & community resources. • Develop a West Coast district centre of excellence for CVD and stroke rehabilitation in concert with the refurbishment of the AT&R Unit at Grey Base Hospital, with a community outreach component for post-discharge rehabilitation, follow-up care and monitoring (to lower risk factors for unplanned returns). • Feedback from CVD Service Development Group to be integral to any additional planning for future local service improvements in primary and secondary service delivery of CVD and Stroke rehabilitation and support	• No definitive dates for the completion of this service re-focus have been determined at this stage, including: - Refurbishment of the AT&R Unit completed. - Establishment of a CVD and Stoke rehabilitation centre of excellence. - Establishment of a cardiac rehabilitation outpatient programme. - Establishment of data collection and monitoring of people who have suffered a CVD event who attend a cardiac rehabilitation outpatient programme. • Still under development.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	services within the local context. • **POP-02 CVD Services.** **Numerator:** (Data source: DHB) The number of people who have suffered a CVD event who attend a cardiac rehabilitation outpatient programme as defined below. **Denominator:** (Data Source: DHB) The number of people who have suffered a CVD event who were admitted and discharged from hospital.	• Data not yet collected. • These action points have been rolled through to the 2006/07 DAP for implementation.
Priority – Improving Oral Health		
Promote water fluoridation as a safe and effective means of improving West Coast oral health	• Provide information to key stakeholders and the public about the benefits and risks of water fluoridation. • Work with all relevant organisations to encourage the introduction of optimal levels of fluoride to West Coast water supplies. • % of 5 and 12 year old children receiving fluoridated water supplies (Source: SDS data).	• Significant engagement with TLAs, schools, health and social service providers occurred but resistance from opponents of water fluoridation led to a referendum by the Grey District Council. The outcome of this was a significant majority against fluoridation of water and as a consequence this initiative was discontinued. • This specific objective was not achieved for the reasons identified above.
Adolescent Oral Health Regional Coordination Scheme	• Continued roll-out of the multi-media campaign. • Engagement with schools and local health providers. • Participation of Adolescent Oral Health Promoter in WCDHB Youth Health Committee. • % of adolescents attending the dentist (Source: HealthPAC).	• Continued roll-out of the multi-media campaign – Achieved. • Engagement with schools and local health providers – Achieved. • Participation of Adolescent Oral Health Promoter in WCDHB Youth Health Committee – Not Achieved. • % of adolescents attending the dentist (Source: HealthPAC) – Data not available.
School Dental Service Review implementation	• Develop and implement a new delivery infrastructure for the SDS within the recommendations made by the SDS Review but contingent on the outcome of the Minister's report and Cabinet approval for additional funding. • This process must include full consultation with affected groups and communities.	• This objective has been superseded by the SDS Review and Ministers' decision to fund child and adolescent oral health through addition vote health funding. Consequently WCDHB will be submitting a proposal for funding of new service provision (including a community engagement / consultation process during 2006/2007.
Child Oral Health	• Explore options for further initiatives in Maori Oral Health as they arise from the Hui to be held in March 2004. • Continue to monitor SDS data, including age at first enrolment. • Tamariki age at first enrolment. **POP05 Percentage Caries Free at age 5 years.**	• This was not achieved during 2005/2006. • There are no fluoridated public water supplies on the West Coast. • **POP05 Percentage Caries Free at age 5 years.** Average rate (non fluoridated) for 2005/06 = 43.09%.

<table>
<tr><th>Output</th><th>Performance Target to 30/6/06</th><th>Actual Performance to 30/6/06</th></tr>
<tr><td></td><td>
<table>
<tr><th></th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>Non-Fluoridated</td><td>40%</td><td>-</td><td>49%</td></tr>
<tr><td>Fluoridated</td><td>-</td><td>-</td><td>-</td></tr>
</table>
POP06 Mean DMFT at Year 8 (Form 2).
<table>
<tr><th></th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>Non-Fluoridated</td><td>2.80</td><td>-</td><td>2.00</td></tr>
<tr><td>Fluoridated</td><td>-</td><td>-</td><td>-</td></tr>
</table>
</td><td>
POP06 Mean DMFT at Year 8 (Form 2).
Average rate (non fluoridated) for 2005/06 = 1.95.
</td></tr>
<tr><td colspan="3">Priority – Child and Youth Health Services</td></tr>
<tr><td>Low Birth Weight Babies</td><td>Low birth weight infants are more susceptible to serious illness during infancy and early childhood and in adulthood. Prevention strategies can reduce these long term impacts for individuals, for health services and the wider society.
Support the development of a primary, secondary and tertiary preventive approach to disease prevention and management that starts at conception.</td><td>This was achieved during 2005/2006.</td></tr>
<tr><td></td><td>Ensure the continued availability of antenatal parenting and pregnancy education programs to pregnant women (and their partners), which includes information about risk factors, particularly with respect to smoking and nutrition - and ensuring that women understand the signs and symptoms of preterm labour.</td><td>14 Pregnancy and Parenting Education courses were conducted by the DHB Provider Arm Services in 2005/06.</td></tr>
<tr><td></td><td>Encourage the Primary Health Organisation (PHO) and Lead Maternity Carers (LMCs) to ensure that a risk profile of pregnant women is recorded particularly with respect to smoking and nutrition.</td><td>Smoking and nutrition status are recorded and any changes monitored throughout the pregnancy as part of risk profiling for pregnant women so that appropriate education advice can be offered and provided on an individual basis.</td></tr>
<tr><td></td><td>Continue to ensure Tertiary prevention of low birth weight babies through the use of interventions while the woman is in preterm labour to reduce health problems for the baby.</td><td></td></tr>
<tr><td></td><td>Monitor data to assess need for further initiatives.</td><td></td></tr>
<tr><td></td><td>POP- 09 Low birth weight babies - Rate per 1000 births. Data for this measure is supplied through the Ministry of Health by ethnicity.</td><td>POP- 09 Low birth weight babies - Rate per 1000 births West Coast rates for low birth weight babies did not vary significantly from the overall national rates at the 99% confidence interval (and were, in fact, slightly lower).</td></tr>
</table>

<table>
<tr><th>Output</th><th>Performance Target to 30/6/06</th><th>Actual Performance to 30/6/06</th></tr>
<tr><td>Implement the Baby Friendly Hospital Initiative in maternity facilities</td><td>Achieving accreditation, as BFHI requires a commitment to service quality, it is low cost and ensures the alignment of policy and practice, with on-going educational support for health professionals.
Support the implementation of the Baby Friendly Hospital Initiative at Grey Base Hospital and Buller.
Ensure continued access to parenting and pregnancy education to all pregnant women and their partners.
Increase breast-feeding promotion, advocacy and coordination on the West Coast, especially that which is acceptable and appropriate to Maori and Pacific Island families / whanau.
Monitor breast-feeding data to assess need for further initiatives.
POP-10 Progress in implementing the Baby Friendly Hospital Initiative in maternity facilities.
Meeting Ministry of Health Breast Feeding targets for 2005.
<table><tr><th>Exclusively/fully breast feed at</th><th>2005</th><th>2010</th></tr><tr><td>6 weeks</td><td>74%</td><td>90%</td></tr><tr><td>3 months</td><td>57%</td><td>70%</td></tr><tr><td>6 months</td><td>21%</td><td>27%</td></tr></table></td><td>BFHI Accreditation of Buller and Grey Hospital facilities achieved in 2005 and continues.
Ministry of Health Breast feeding targets for 2005 were met.</td></tr>
<tr><td>Progress towards the national target of 95% of 2 year olds fully immunised.</td><td>Improving immunisation coverage is a key component of the NZHS; “to improve child health”. High immunisation coverage is necessary to prevent vaccine preventable diseases in individual children, and in the general population.
Successfully implement the National Immunisation Register, to ensure accurate monitoring of Immunisation rates within agreed time frames.
Use the implementation of the NIR and the Meningococcal B Vaccination Strategy as a way to promote the health benefits of immunisation.
POP-12 Progress towards the national target of 95% of two year olds fully immunised.
Implementation of the National Immunisation Register.</td><td>This was substantially achieved and recognised for outstanding performance with the exception that our ability to meet the 95% target was effected by two specific community groups declining vaccination.</td></tr>
<tr><td>Reduce the number of Ambulatory sensitive admissions - Children</td><td>Better access to preventative health care (well child) and treatment at primary care for respiratory illness, cellulitis and other skin conditions, and gastric illnesses are expected to reduce the number of acute admissions.
Work with CPH and other providers to</td><td>Positive reinforcement of healthy decisions was made by schools.</td></tr>
</table>

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	support the maintenance, further development and implementation of the health promoting schools initiative.	• This was achieved.
	• Encourage CPH work through the Heart Foundation to promote the Healthy Heart Award to early childhood centres.	• Given the importance of the Meningococcal B vaccination Programme, there was limited work on the Health Promoting Schools Initiative during the duration of the Immunisation Programme in 2005/06.
	• Monitor disparities between age and population groups to assist the Child and Youth Health Committee with planning to reduce disparities.	• The current percentage of registered Health Promoting schools on the West Coast is 2.8% [-just one school (Runanga Primary school) is formally enrolled with the framework]. Notwithstanding this, Public Health Nursing services, with the support of Community and Public Health, were active in working with other schools throughout the West Coast region to encourage the uptake of the Health Promoting schools framework, encouraging healthy schools environments, and HEHA related programmes such as Spring into Action.
	• **POP-13 Ambulatory Sensitive Admissions** - Children Discharge rate per 1000 population. Data for this measure is supplied through the Ministry of Health by ethnicity. Where the West Coast DHB ethnic rate is significantly greater than the total New Zealand (all ethnicity) national rate at the 99% confidence interval, West Coast DHB will provide narrative commentary, including comment on any current or planned initiatives likely to influence future outcomes specifically for the effected population group(s) as appropriate. • Increased number of EEC with Health Heart programmes.	• **POP-13: Ambulatory Sensitive Admission Rates** West Coast rates for ambulatory sensitive admissions for children under 5, for those aged 5-14, and for youth aged 15-24 years did not vary significantly from the overall national rates at the 99% confidence interval. Data for this measure is generated centrally by the Ministry of Health.
Priority - Progressing the NZ Primary Health Care Strategy		
Work to implement West Coast DHB's Primary Health Care Strategy	• Strategy will have been developed by end of 04/05. The 05/06 year should see concerted progress towards implementation across a broad range of issues.	• Delays in the completion have occurred during the preparation of the primary care strategy meaning that this was not fully implemented in 2005/2006.
	• Progress should be in partnership with PHO wherever possible.	• There has been significant progress in partnership activity between West Coast District Health Board and West Coast PHO. This has included a range of primary health promotion and provision activities.
	• SER-01 Primary Health Care: Ratio of age-standardised GP consultations by high needs individuals to non-high needs individuals will be at least one, once data becomes available. SER-04 At least maintain and preferably improve the number of shared roster areas with on-call rosters worse than 1:4.	• The ratio of high to non-high individuals' consultations is still targeted to be one to one.
Develop, Maintain and Recruit a Skilled	• Implement the workforce strategy in the West Coast Primary Health Care Plan.	• The Neighbourhood nurse pilot is due for completion in December 2006. Evaluation of this

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
Multi-disciplinary Primary Health Care Workforce	• Continue to support continuing education through the (PHO). • Address the changing requirements in skill mix and increased diversity of roles and functions in the changing primary health environment on the West Coast. • Support the development of the primary nurse practitioner role. • Encourage and support the development and implementation of the locally developed training scheme for rural GP's. • Support initiatives and strategies which aim to recruit and retain sufficient GP's and nurses on the West Coast. eg. Overseas recruitment, reasonable rostering funding, workforce recruitment and retention funding. • Implement Neighbourhood Nurses proposal. • The West Coast DHB will monitor the proportion of rural workforce roles that are filled and turnover rates.	pilot will provide future direction for the development of a primary health nurse workforce. • The West Coast Rural GP training scheme has been adopted and enrolees are being sought for 2006/07. • A Nurse practitioner working party has been formed and planning is well advanced for the development of a business case to support the establishment of primary nurse practitioner positions. • Maintenance of workforce numbers continues to be supported by DHB funding for reasonable rosters and recruitment and retention. Recruitment of GPs has improved in the past year with the successful recruitment of vocationally registered GPs who wish to move permanently to the West Coast.
To Manage Pharmaceutical and Laboratory Spending on the West Coast	• Implement West Coast Primary Health Care Strategy. • Work through the PHO to collect information on pharmaceutical and laboratory spending trends on the West Coast; and to manage increasing demand through a risk sharing approach. • Support the continuing education for referring practitioners on best practice prescribing. • Risk sharing where possible. • Consider the role of and opportunities for the West Coast DHB Laboratory in undertaking additional community laboratory work. • Encourage the use of generic medicines, where clinically appropriate.	• Accurate prescribing and referral trend information is being reported regularly on a quarterly basis. This will enable education on better prescribing/referral practice to occur in 2006/2007 and to help keep expenditure within agreed targets. • More work will occur on this during 2006/2007.
To Improve Maori Input into PHO Decision-making	• PHO adopts a Maori Health Plan. • PHO Maori Health Plan contains appropriate linkages to Runanga, Maori service providers and communities. • SER-02 Maori involvement in PHO decision-making.	• The PHO developed and adopted a Maori health plan in 2005/2006 that include linkages with local Runanga, Mata Waka and Maori health providers. • West Coast PHO has Maori representation on it's board of governance.
Priority - Developing Health Infrastructure: Workforce (including Employee relations strategies and implementing the DHBNZ WAP)		
Achieve Collective Employment Agreement settlements within legislative and	• Collaborate with other DHBs to provide negotiation teams with requisite information and data to expedite reaching settlement. • Prepare in advance by involving key staff members in a review process of existing agreements and recommend	• All collectives were settled within the budget parameters set by the Ministry. Few collectives were settled in a timely manner due to various reasons, eg: industrial action, claims that exceeded budget parameters etc. • The HR manual is undergoing a complete review. Some policies have been simply reviewed and

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
budgetary parameters, specified timeframes with organisational specific factors recognised	changes to facilitate the cost effective management of our 'human resource'. • Designate key staff members to participate in negotiation. Monitor negotiation progress and alert the organisation to potential operational impediments/implications so that preventative action can be taken prior to settlement. • Ensure key staff members involved in this process are conversant with employment legislation and abide by its principles. • Meeting budgets set and remaining within DAP financial parameters. • No successful Personal Grievance claims.	others are in need of re-writing. Some new policies have been identified (remuneration, reward and recognition) are being developed. • Less than a handful of employees have required formal interventions around performance management. As figures for previous years have not been kept it is difficult to make statements about whether this is a reduced number. In addition it is difficult to state categorically that all performance issues have been raised and addressed within the organisation. It would not be prudent to expect this to be so. The development of a robust performance management system that is easily applied will benefit the Board. • PG claims outstanding from previous years were settled during this year. Two went to the employment authority with one result still reserved. The other was successfully for the DHB. One other claim went to mediation with a good outcome for the Board. • One PG from 05/06 went to mediation with a good result for the Board. • Size of DHB limits our ability to influence direction of negotiations especially with regard to national MECAs., however the Board has ensured it has been as involved as it can be with negotiations for MECA's. • The Board has followed each set of negotiations closely and alerted the national DHB team if proposals carry any risky options for the Board. Strategies have been developed before negotiations have been entered into for local collectives. • Recruitment workshops were implemented in April 06 to ensure that lead recruiters were not only following policy and procedure, but also had an understanding of the theory behind good recruitment process. This process will be followed for other HR Policies in 06/07. • On-going coaching occurs during each recruitment process as well as small workshops as required. e.g. Workshops on tax implications of added benefits and allowances.
Maintenance of "Good Faith" Employment/Industrial Relations	• Negotiate with staff (individually and collectively), employee representatives and unions as appropriate and consistent with relevant legislation. • Ensure 'good employer' obligations as defined by the NZPHDA are maintained and also that fair and appropriate conditions of employment are maintained consistently throughout the organisation. • Compliance with DHBNZ Code of Good Faith. • Collaborate with all regional and national negotiations. • Workforce is free of disruption - no industrial action taken by staff.	• All contract negotiations proceeded on the basis of responding to claims laid by Unions in a manner of good faith. Budget parameters have been met. Time frames have been hard to meet. • The Board has ensured that contingency plans are well considered and planned well in advance as directed by Ministry and DHBNZ, lead Advocates etc. • DHB's have experienced some industrial action. The Board approached this with the view that all parties would need to work together afterwards. The non-confrontation approach the Board has portrayed has had good results during both periods of strike action. On going relationships with all Unions remain good.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	• New employment agreements concluded and implemented smoothly.	• Board has retained good links with DHBNZ & MoH throughout and ensured most information sharing has occurred within the required time frames.
Recruit And Retain Sufficient Qualified Staff	• Collaborate with other DHBs and NZ Immigration Services to efficiently and effectively recruit overseas clinical staff. • Continue to foster a good working relationship with the NZ Medical Council. • Enhance the collaborative and consultative relationship between Clinical staff and Management to achieve organisational effectiveness. • Participate with MOH and other DHBs on national workforce planning strategies. • Continue to collaborate with other West Coast organisations to develop the West Coast as a lifestyle choice when deciding on employment options. • Work with external recruitment agencies, locum and permanent, public and privately funded, when necessary to secure staff required. • Identify and develop a plan to address, the impact of professional isolation on the organisations ability to retain key staff. • Average length of service increased and turnover decreased. • Complete Workforce Development Plan consistent with the DHBNZ Workforce Plan and the Workforce Action Plan. • Implementation of the health workforce recommendations of the General Surgical Services Review.	• To minimise staffing shortages, the recruitment function has focused on permanent employment during the last 9 months of the year. A reasonable amount of success has resulted via media recruitment campaigns in the UK on three separate occasions. Recruitment of clinicians for General Surgery, General Practice and O & G has been via networking and personal referrals and this has had very successful outcomes. Nursing shortages were overcome to a large degree via several strategies that included the return to nursing course in Feb 06 and the graduate nurse programme. • The retention strategy requires additional resourcing to ensure that good effective programmes are in place to reduce turnover for new staff. The Board is still experiencing a fairly high rate of turnover for employees who have been with the Board for less than 2 years. • Staff turnover percentages reduced. The HBI illustrates a reduction in turnover for the DHB throughout the last four quarters. • National and international workforce shortages has affected our ability to recruit Pharmacists, Physios OT's, Financial as well as Nurses and Dr's in the short term, however provided planning is in place then it is possible to recruit long term to cover shortages by campaigning abroad. • Greater restrictions on immigration to NZ of overseas travelled health professionals, and stricter clinical practices requirements of such persons have been felt when changes are made to NZ immigration restrictions. In addition immigration policies in other countries have also affected on our ability to recruit as well. • The employment of a dedicated recruitment coordinator resulted in huge gains for the Board during the year. Good relationships have ensured the Boards ability to move reasonably smoothly through Medical Council processes. Local HR connections have been established with two employers in the region. S Island DHB relationships have benefited from group E-recruitment initiative that is on-going. • Occupational Shortage and Priority Occupations List. issues are regularly raised at National level by HR Managers to ensure that appropriate information is exchanged with Immigration services. • Collaboration has occurred with a wider audience – South Island DHB's and also with some North Island DHB's.
Develop the Maori Health And Disability Workforce on the West Coast	• Implementation of recommendations of Te Waipounamu Maori Workforce Development Plan 2005-2010, particularly those recommendations relating to the West Coast. • Co-ordinate the development of a Maori	• Regular meetings occurred to move forward with the development of the Maori Health Workforce plan. Ethnicity Data collection training occur early in the year. Further regular training is planned to occur in 06/07, delays have occurred to developing internal training package – mainly a resourcing issue. No forward movement either to collecting

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	Workforce Development Plan (as part of the organisation-wide Workforce Plan) aimed at improving numbers and staff mixes. • Identify barriers to Maori participation in the workforce and develop strategies to reduce barriers. • Work with Maori staff to create a supportive and culturally appropriate environment. • Continue programmes to improve cultural awareness within the organisation. • Strengthen inter-agency links and training opportunities between the DHB and Rata Te Awhina Trust, and other health providers and agencies involved in Maori Health/Workforce. • Increase in number of Maori employed by the West Coast DHB, especially in clinical positions. • Increase in number of Maori accessing and utilising developmental opportunities that have been initiated by West Coast DHB in conjunction with tertiary providers.	data on employee ethnicity. Database needs to be developed, again this hasn't happened due to lack of available resources. • Maori Staff hui continued throughout 05/06; the last hui was held towards the end of the year. Further hui planned for 06/07. • An initiative to collaborate with tertiary education providers, to facilitate the return to the work force of Maori who are e.g. unemployed or who have been caring for children has not occurred. However CPHC requested papers be developed for scholarships during the year. The Board requested management to develop this initiative for implementation in 2007. Maori will be one of the targets for scholarships. • It is difficult to show whether the Board has attracted more Maori to the workforce as employee ethnicity data is not collected. This data collection is priority for 06/07 as it is critical that we are able to view and understand this data. • Recruitment of any position goes through a process that ensures adverts are placed in appropriate media to attract the right candidate. Few positions are specifically for Maori. • Orientation day now includes Kaumatua welcome and introduction, and GM Maori Health discusses Maori health and inequalities. Inequalities lens is applied to major decision making at EMT level and this will reflect in the workforce development in the future.
Strengthen and Develop the DHB Workforce	• In alignment with DHBNZ WAP frameworks, develop a workforce plan for the DHB that identifies numbers of staff and requisite competencies and provides resources and pathways to ensure staff achieves those competencies. • Continue to develop career pathways for nurses. • Support needs and evidence based staff training/development programmes aimed at matching competencies with organisational requirements. • Further develop the Performance Management Programme to enhance staff performance. • Maintain and continue to develop the company-wide generic Staff Development programme that includes Orientation for all new employees, the implementation and monitoring of the Mandatory Training Programme and the development of new Staff Training Programmes – clinical and non-clinical. • Report on progress on activities that support the DHBNZ/DHB work force action plan.	• Organisation wide Training Needs Analysis; targeted at all those individuals who have staff responsibilities i.e. 4th tier and upwards. This was completed. Staff training and development committee re-instated in Oct 05. Terms of reference agreed. • Development of an organisation wide training plan - meeting planned for July 06 was to develop this plan. • Monitoring and evaluation of staff development programmes – on going. STD committee meetings were erratic. Mandatory training was overhauled and availability was changed with reasonable results e.g. full days or one session options. Staff like some of the changes. However still finding issues with attendance at Buller and Reefton. Video training is used occasionally and has been fairly successful. • Orientation is provided by EMT. This has been well received by new employees, good opportunity to meet senior management informally and gain an understanding of the vision and how the organisation is intending to make the vision a reality. New training initiatives investigated have been defensive driving and resuscitation at a higher level than previously delivered, both planned to be implemented in 06/07.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
Occupational Health and Safety	Actively pursue and promote the goal of excellence in the Management of Health & Safety in the workplace by providing advice and support to Managers and employees and demonstrating application and ongoing awareness of quality accreditation standards within workplaces. • Maintain an audit programme for the West Coast DHB's compliance with the Health and Safety in Employment Act. • Maintain appropriate educational programmes that respond to identified Health & Safety needs. • Maintain strategies of screening, monitoring and surveillance of West Coast District Health Board employees at risk to specific biological, physical, ergonomic, chemical environmental hazards. • Maintain specific preventative programmes such as Injury Prevention, VDU users work safe practices and personal protection equipment. • Maintain the Hepatitis B vaccination and MRSA programmes. • Retaining tertiary level rating through the ACC Audit. • Maintaining a decreasing figure for hours lost due to WRI.	• Consistently good results have been returned from the Occupational Health and Safety Team. The employment of a part time Occupational Nurse has ensured a good delivery of programmes for managing employee health and wellbeing. Good results continue to be had from rehabilitation programmes. • Health and safety representatives have received level 2 training this year. • The whole organisation rose to the occasion throughout the year as the Board worked towards achieving tertiary status once again for the Workplace Safety Management Practice Programme. This was achieved in June 2006. However the Board will continue to need to improve and to put in place the "best practise" suggestions offered by the ACC auditor. • In the four quarters the work rate injury rate dropped steeply for the first three quarters and then stabilised in the last. This was an excellent outcome for the Board. • Sick leave for the Board was one of lowest recorded by all the DHB's at an average of 2.7% for the four quarters of the year. However more work still needs to be done.
Priority - Developing Health Infrastructure: Information Management (including alignment with the WAVE project)		
Information Management Initiatives/ Capability: **Identifying Interventions West Coast DHB Will Use To Meet The Indicator Targets**	The NZHS specifically recognises development of information management and technology as a key area where development is required to achieve the aims of the strategy. The WAVE Report is the strategy for sector information management. Achieving the goals of the WAVE report relies on improvements to the quality of electronic health data and increasing use of electronic information. Reporting on these measures provides an indication of the degree of progress being made to improve the capability of the sector to exchange information in a safe manner. In collaboration and consultation with both Southland DHB (SDHB) and Otago DHB (ODHB), the West Coast DHB has selected a replacement Patient Management System/Clinical Information System (PMS/CIS); the preferred vendor is iSoft. This project has as one of it's stated objectives "to align systems with the current strategic direction of SouthernALLIANCE [the shared services agency] and as supported by the Government WAVE project". The goal here is to begin to align the West Coast DHB's information and technology investment with the WAVE Report priorities and HIS-NZ action zones and building guides during 2005-2006 (refer to the West Coast DHB ISSP for more detail).	• Work with SDHB and ODHB to implement the selected iSoft PMS/CIS by having input into the planning and implementation phases of the project. • Isoft PMS has been implemented successfully within WCDHB. All users went live with the new system on 1st July 2006. Part of the Isoft rollout included 50 additional terminals throughout the DHB. The largest outstanding issue is the availability of reports. There are approximately 700 reports to rewrite. As planned, post go live reports are being prioritised and re-written within the new system. It is expected this will take some time to finish completely. • Extend and enhance the Primary Integration Systems Management (PrISM) Project, completed in 2004/2005, enabling more Primary practices to access clinical knowledge bases such as Cochrane and Medline. • Reefton Medical Centre has since been moved onto PRISM successfully. Isoft PMS system has been made available over PRISM. PACS will be available over PRISM within the next month. • All WCDHB staff have access to online medical databases such as (such as Cochrane and Medline) either online, or in the case of WCDHB's only non-computerised site (Haast) via the West Coast DHB's internal library service. • All WCDHB GP practices have access to

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	INV-01: Information Management Initiatives/Capability The foundation principle of the approach West Coast DHB is taking is that the right information is available to the right people, in the right place at the right time. Whilst this will take time to fully achieve, all information initiatives will seek to further this requirement. This principle will enable West Coast DHB to: • Report on the number and percentages of clinical FTEs, by major clinical grouping, that has access to which clinical knowledge bases (such as Cochrane and Medline). • Report on the number and percentages general practices using electronic decision support guidelines endorsed by the NZ Guidelines Group, particularly for cardio-vascular, diabetes and referrals. • Report on the volumes and percentages of discharges, broken down by service area, e.g. orthopaedic, mental health, using electronic messaging software to notify primary care providers of relevant patient details on hospital discharge. The electronic means used should be specified. • Report on the number and percentages of DHB funded referring practitioners electronically generating laboratory order scripts, receiving laboratory results and electronically generating pharmaceutical scripts. • Report on the extent to which WCDHB has implemented and is complying with sector standards for security and privacy. This includes the Health Information Privacy Code 1994, the Health Network Code of Practice and any other related standards or practices formally agreed between the Ministry and WCDHB.	electronic decision support guidelines endorsed by the NZ Guidelines Group, particularly for cardio-vascular, diabetes and referrals, primarily via the internet. • Reporting on the volumes and percentages of discharges, broken down by service area, e.g. orthopaedic, mental health, using electronic messaging software to notify primary care providers of relevant patient details on hospital discharge will be available at the completion of the iSOFT project (target date 30 October 2006). • All WCDHB GP practices are electronically receiving laboratory results. As yet, none are generating laboratory order scripts or electronically generating pharmaceutical scripts. • West Coast DHB complies with Health Information Privacy Code 1994, the Health Network Code of Practice and other related.
Priority - Improving Immunisation and Progressing the Meningococcal B Vaccine Strategy		
Implement Meningococcal B vaccination Strategy	• Successfully implement the National Immunisation Register, and School Based Vaccination System to ensure accurate monitoring of Meningococcal B Immunisation rates. • Roll out the Meningococcal B Vaccination Strategy through both school based and primary care programs. • RIS-03 Progress towards the implementation of the Meningococcal B Immunisation Project including meeting	• Target 90% of receiving 3rd dose of MeNZB™ vaccine as at June 2006. – 6 weeks – under 1 year = 47.8% – 1- 4 years = 74.59% • Target of 90% of school-enrolled children receiving 3rd dose of MeZNB™ vaccine = 87.2%. • Overall population – 5-17years completion of receiving 3rd dose MeNZB = 84.65% – Target of 90% of under 20's out of school receiving 3rd dose of MeZNB™ vaccine,

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	targets set therein.	– 18-19 years receiving 3rd dose MeNZB = 60.68% • Outreach – Community clinics, these began February 2006. Mop up for hard to reach/at risk population for MeNZB will focus on youth and under 5's going forward. Up to June 2006, there had been 943 referrals to outreach with 805 outcomes to date.
Priority - Implementing the NZ Cancer Control Strategy		
Implementing the Cancer Control Strategy	WCDHB is committed to developing a comprehensive implementation plan that will support the six goals of the cancer control strategy within available resources. The plan will focus on the six goals as follows:	Our 2005/06 District Annual Plan identified that the West Coast DHB would embark on several service development and planning group work-streams, (within specified timeframes), around cardiovascular disease, stroke care management, cancer control, respiratory and palliative care services on the West Coast (including the phased delivery of both the national Palliative Care Plan and the Cancer Control Strategy Plan to deliver appropriate services in place that meets the strategy within available resources). Further work undertaken since the 2005/06 DAP was completed identified much commonality and many inter-related issues that cut across these various chronic conditions; such that a more holistic and comprehensive approach to planning service improvement and integration was more likely to produce better outcomes than was looking at the individual conditions in isolation. To this end, planning focus shifted to developing a comprehensive Chronic Conditions Care Management work plan that would overarch improving management and best practice principles for services on the West Coast, rather than a series of condition-specific working parties. Work on the Chronic Conditions Care Management strategy commenced in October 2005. The Chronic Conditions Care Management Plan was largely completed by June 2005, and is due to be finalized and presented to the DHB Board in early 2006/07 for review and approval. The Plan covers all stages of the health and illness continuum for people with chronic conditions in terms of optimizing a healthy environment; providing for at risk populations; managing the acute event; initial management (first six months) of a chronic condition; and the longer term management (over six months) of a chronic condition. Across each of these five major categories in the continuum, the plan looks toward improvement in the following seven elements over the next three years in the West Coast setting: healthy systems (organization of health care); community resources and policy; delivery system redesign; decision support; clinical information systems; self management; and equity in health including access to and outcomes of health care. During 2005/06. WCDHB committed to the Cancer Control Strategy in the following ways:
	1. Reduce the incidence of cancer through primary prevention - Target areas for 2005/06: • Encourage healthy lifestyles through smokefree initiatives, the Quit Smoking programme, initiatives aimed at increasing physical activity levels, reducing obesity, and improving nutrition, support education	**1. Reduce the incidence of cancer through primary prevention** a. Encouraged healthy lifestyles through: • The active delivery of smoke-free initiatives in primary practice, as well as the Quit Smoking programme through our Provider Arm services;

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	around avoiding sunburn, promoting sexual health and reducing alcohol consumption – with particular emphasis in 2005/06 on tobacco control and nutrition (also: see sections on Tobacco Control and on Implementing the Health Eating, Healthy Action Strategy below). • Through the WCPHO, continue to provide education and support to primary and community providers in identification of risk factors, screening and early intervention. • Use data from the 2004/05 West Coast Health Needs Assessment Profile to target local health promotion initiatives relating to cancer risk factors – additionally, promoting the accurate collection of ethnicity data of both WCDHB and WCPHO services as a vehicle to update and inform such initiatives into the future. • Continue to liaise with and support the work of the West Coast Cancer Society and the Buller-West Coast Home Hospice Trust.	• Roll-out of initiatives aimed at increasing physical activity levels, reducing obesity, and improving nutrition - included the Sea-to-Sea Challenge over a six-week period during October and November 2005 that involved 500 people Coast-wide in physical activity; the implementation of new HEHA polices within DHB premises as a role model for others in the community; ongoing participation in Active West Coast (a collaboration of groups/organisations trying to get more West Coasters more active more often); ongoing delivery of the Appetite for Life programme (a 6-week programme designed to assist women Coast-wide with the long-term objective to help them to achieve self-motivated healthy, active lifestyles); and the delivery of the "Spring into Action" Challenge programme. The "Spring into Action" programme this time involved over 1500 people Coast-wide in physical activity (including over 500 children) over a six-week period for adults/four-week period for children, between May and June 2006. [Our 2005 "Spring Into Action" programme was named as a finalist in the New Zealand Health Innovations awards for 2006. The 2005 programme also saw the West Coast DHB win the award in the large organisation category in the Push Play Activity Friendly Business Awards in December 2005 for best physical activity workplace initiative]; • Ongoing support and education around avoiding sunburn, promoting sexual health, and reducing alcohol consumption through primary and secondary services. b. Through the WCPHO, continued to provide education and support to primary and community providers in identification of risk factors, screening and early intervention. c. Commencement in January 2006, of a pilot study to map the patient journey and clinical pathway of adult people on the West Coast who have a diagnosis of cancer – a joint venture project between the West Coast DHB, West Coast Cancer Society and the Buller-West Coast Home Hospice Trust. This Project has a focus toward identifying if the journey is significantly different for Maori compared to non-Maori, and is aimed at informing the three principle project sponsor organisations about current gaps in service, or areas for service improvement that need to addressed, to smooth that journey for other people into the future. The study will assist the three sponsor organisations in the future design of their respective cancer services, to maximise their focus on the patient needs in order to improve better outcomes and patient experiences. The Project report is due to be completed mid-late September 2006.
	2. Ensure effective screening and early detection to reduce cancer incidence and mortality - Target areas for	**2. Ensure effective screening and early detection to reduce cancer incidence and mortality** • WCDHB continued to support local and

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	2005/06: • Continued support local and national Cancer Screening Programme initiatives and service extension on the West Coast, particularly those initiatives aimed at targeting at risk and hard to reach individuals. • Encouragement of WCPHO involvement and linkages into local screening initiatives.	national Cancer Screening Programme initiatives and service extension on the West Coast, through the ongoing provision of a cervical screening services, as well as direct physical support and on-site accommodation of the visiting mobile mammography screening unit of Breastscreen Aotearoa at Grey Base Hospital, during visits from 7 March – 4 July 2005 and again from 30 May to 31 August 2006 (– and due back again is May 2007). • WCPHO is actively encouraged to have involvement and linkages into local screening initiatives. WCPHO representatives – along with representatives from other NGO service providers - were directly involved in the development of our Chronic Conditions Management strategy planning – of which cancer control has been made a part. (See introductory above). Additionally, the WCPHO-DHB's GP Liaison is directly involved in the pilot study to map the patient journey and clinical pathway of adult people on the West Coast who have a diagnosis of cancer (see above).
	3. Ensure effective diagnosis and treatment of cancer to reduce morbidity and mortality - Target areas for 2005/06: • 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 - working in concert with the WCPHO, Maori service providers, the West Coast Cancer Society, the Buller-West Coast Home Hospice Trust. • During 2005/06, continue the work commenced in 2004/05 to increase the volumes of chemotherapy provided on the West Coast to reduce the need for West Coasters to travel to Canterbury to receive treatment – within available resources. • Monitoring of waiting times for West Coast residents receiving radiotherapy treatment provided through Canterbury DHB.	**3. Ensure effective diagnosis and treatment of cancer to reduce morbidity and mortality** • As above, a pilot study to map cancer patient journeys and clinical pathways was commenced in January 2006. The outcomes of this study will help identify current gaps and be used to help drive future planning, provision, and appropriate coordination and integration of services provided for West Coasters with cancer. • WCDHB continued to increase the volume of chemotherapy provided on the West Coast during 2005/06 to reduce the need for West Coasters to travel to Canterbury to receive treatment. During the financial year to 30 June 2006, there were 317 attendances for chemotherapy treatments delivered locally – up from 287 the previous financial year. First Specialist (FSA) and Follow-up attendances at visiting specialist oncology outpatient clinics conducted on the West Coast were also up over the same period – with FSAs up from 67 last year to 80 this year and follow-up from 426 to 503. • Monitoring of waiting times for West Coast residents receiving radiotherapy treatment provided through Canterbury DHB was ongoing throughout 2005/06.
	4. Improve the quality of life for those with cancer, their family and whanau through support, rehabilitation, and palliative care - Target areas for 2005/06: • In collaboration with the West Coast Home Hospice Trust, palliative care specialists, Maori service providers, and other key stakeholders, develop a long-term sustainable plan to meet	**4. Improve the quality of life for those with cancer, their family and whanau through support, rehabilitation, and palliative care** • As above, a pilot study to map cancer patient journeys and clinical pathways was commenced in January 2006. The outcomes of this study will help identify current gaps and be used to help develop a long-term sustainable plan to meet the Palliative Care Strategy within the West Coast context.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	the Palliative Care Strategy within the West Coast context. • Continue to provide ongoing education and training opportunities for DHB nursing staff to up-skill in cancer and palliative care nursing.	• Our resident Oncology/Palliative Care Resource Nurse Coordinator took extended one-years leave to travel overseas during 2005/06. During her time away, she has worked in oncology units in hospitals in the United Kingdom in order to learn latest best practice techniques employed in the treatment and management of cancer patients, and will bring these skills back to the West Coast upon her return. WCDHB seconded and trained a replacement Nurse Coordinator to ensure the roles and functions of this position were not diminished in the interim. • Additional funding provided in August 2005 for the direct provision of palliative care services was used on a flexible basis to pay for new hospice services for individual patients requiring care in areas away from main centres where current hospital palliative care services exist, and/or assist them to be close to family to improve access and support in the end stages of their life. The provision of these additional flexible funding were deployed to pay for individuals in residential care close to their communities of interest where services are not usually funded through our DHB; for the extension of home carer support to families in rural areas; and for the purchase and hire of special equipment (temporary wheelchair ramp into the home, and special mattresses and cushions); - all of which have allowed patients to remain at home to spend their last days in familiar surroundings with traditional supports. Providing such care on an "as needs" basis has been a flexible and effective way of providing palliative care to particular individual people with cancer on the West Coast.
	5. Improve the delivery of services across the continuum of cancer control through effective planning, coordination and integration of resources and activity, monitoring and evaluation – Target areas for 2005/06: • Establish a Cancer Control Strategy Planning Review group begin identifying future priorities for action, planning implementation and defining processes to manage, monitor and review the phased Cancer Control Strategy implementation for the West Coast. • Internally monitor and update the goals and actions of the DHB's Cancer Control Strategy implementation plan.	**5. Improve the delivery of services across the continuum of cancer control through effective planning, coordination and integration of resources and activity, monitoring and evaluation.** ▪ As above, work on our Cancer Control Strategy is now be undertaken in tandem with the development planning and roll-out of the Chronic Conditions Management plan strategy, and will be further informed by the results of the Cancer Control Strategy initiative to map patient journeys and clinical pathways. This will help identify current gaps and be used to help drive future planning, provision, and appropriate coordination and integration of services provided individuals with cancer. Planning can then be progressed in a more effective and informed manner.
	6. Improve the effectiveness of cancer control in New Zealand through research and evaluation - Target areas for 2005/06: • Continuation of staff training in the importance of accurate ethnicity data	**6. Improve the effectiveness of cancer control in New Zealand through research and evaluation.** • West Coast DHB undertook training of DHB staff to further promote the accurate collection of ethnicity data of within both WCDHB primary and secondary services to improve

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	being collected, with follow-up audit of accuracy to improve accuracy and completeness in ethnicity data collections. • Continuing use of latest data in evidence based planning and delivery of cancer and palliative care services to ensure WCDHB is responsive to the needs of its community of interest (within available resources). • Contribute to clinical trials and research into the treatment of prostate cancer, being led and undertaken by the Oncology Department of Canterbury DHB (- direct contribution via our Oncology Nurse). ▪ **POP-15 Implementing the Cancer Control Strategy** Narrative report on progress achieved against cancer control strategy implementation plan.	accuracy and completeness in ethnicity data collections and to better inform outcomes of cancer control initiatives and the benefit they provide to groups at risk into the future. • One of the stated outcomes of the pilot study commenced in January 2006 to map patient journeys and clinical pathways is that we will share our learnings about the experiences of patients living with cancer in rural areas. It is envisaged that these results will be of equal use to other DHBs around New Zealand as much as our own. Data drawn from the study is to be used in evidence based planning and delivery of cancer and palliative care services to ensure WCDHB is responsive to those affected by cancer in our community (within available resources). • West Coast DHB continued to contribute to clinical trials and research into the treatment of prostate cancer, being led and undertaken by the Oncology Department of Canterbury DHB (- direct contribution via our Oncology Nurse).
Priority - Radiation oncology treatment waiting times		
Radiotherapy Waiting Times Radiotherapy services for West Coast patients are provided by Canterbury DHB through direct funding of the service by the West Coast DHB	• **POP-16 Radiation oncology treatment waiting times** Monthly: monitoring of the interval between the patients referral from a medical practitioner to the oncology department, and the beginning of radiation treatment is supplied on time (Data from Canterbury DHB). Report: progress towards ensuring all patients receive oncology radiation treatment according to nationally agreed standards to ensure that new emerging problems are identified early and equitable access levels are maintained between DHB regions (based on data and information supplied by Canterbury DHB).	• Monitoring of the relative waiting times for West Coast residents receiving radiotherapy treatment provided through Canterbury DHB was ongoing throughout the 2005/06 year. It is noted that the raw base starting number of West Coast patients involved is statistically very few. • There were 11 West Coast patients waiting for radiation treatment as at the end of June 2006, giving a ratio of West Coast residents per 1000 (0.363) waiting for radiation treatment. This was higher than the ratio for people usually resident in Canterbury (0.248 per 1000). The West Coast June position was up from the end of previous quarter, when there were 9 patients waiting. The higher year-end ratio for access the service was not reflective however, with West Coast residents having had lower waiting time access ratios than Canterbury residents during other times in the year.
		• A trend over the 2005/06 financial year toward a decrease in demand for people from our region to access radiotherapy services was reversed in the June 2006 quarter, with 19 West Coast patients entering treatment this period (up from 13 in the previous quarter). This number represents a ratio of 0.63 per 1000 West Coasters, compared to a ratio of 0.59 and 0.43 per 1000 respectively from the previous two quarters. The June ratio for the number of people from Canterbury entering the service is 0.71 per 1000. • Referrals for radiotherapy treatment have increased for some urology patients with prostate cancers, who are otherwise too ill and/or have co-morbidities preventing direct surgical intervention.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
		Advanced colorectal cases are also being provided with radiotherapy first before surgery, as research has indicated that this provides better outcomes for patients. This practice has been increasingly used as a treatment regime for West Coast patients over the past two years.
Priority - Implementing Healthy Eating, Healthy Action		
Build healthy public policy to promote healthy eating and healthy action	• Work across sectors to develop policies that are consistent with the aims and objectives of the HEHA Strategy, including DHB participation on the Regional Land Transport Steering Group and Active West Coast. • Support the continued development of Health Promoting Health Services within the West Coast DHB by developing formal policies and procedures to guide staff and organisational activities, including the development of a nutrition policy as a priority. • Work to implement the WCDHB breastfeeding policy continues.	• The HEHA Nutrition Policy was adopted by West Coast District Health Board in 2006/2007. • There are a number of District Health Board District Health Board and interagency collaborative initiatives promoting healthy eating and health action. • The joint initiative on 'spring into action' between District Health Board and C&PH during 2006/2007 received a commendation under the New Zealand health innovation awards during the year. • An exciting innovation in promoting breast feeding achieved funding under the HEHA initiative enabling a breast feeding education programme to be undertaken by West Coast PHO.
Create supportive environments to promote healthy eating and healthy action	• Continue to promote the Green Prescription though primary care providers • The continued development of Health Promoting Health Services within the West Coast DHB with its focus on changing the environment to support physical activity and healthy eating. • DHB is accredited under the Baby Friendly Hospital Initiative as an organisation that provides a supportive environment to promote breastfeeding to new and expecting mothers. • Community and Public Health works in a variety of settings, particularly with kindergartens and early childhood centres, to promote access to healthy food. • % of babies born in a BFHI accredited hospital.	• This was done. • This was done. • This was done. • This was done. • 100% of hospital brths was achieved in BFHI hospitals.
Strengthen community action to promote healthy eating and healthy action	• Community and Public Health's Community Nutrition Project prioritises the high needs communities and supports the development of further nutrition and physical activity programmes by community groups. • Continued interaction, support and collaboration with other health and Intersectoral organisation, including participation on the Active West Coast group.	• This was done. • This was done.
Develop personal skills to promote	• Regular communication ensures ready access to information supporting people and their families and whanau to be	• This occurred through a range of promotional and activity based initiatives.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
healthy eating and healthy action	physically active and eating healthy food. • Initiatives and physical activity challenges support people, their colleagues and families and whanau to become and/or remain regularly physical active. • Community and Public Health and public health nurses continue to work in early childhood education settings to up-skill and support teachers, by providing training opportunities and information to promote physical activity and good nutrition.	• Roll-out of initiatives aimed at increasing physical activity levels, reducing obesity, and improving nutrition - included the Sea-to-Sea Challenge over a six-week period during October and November 2005 that involved 500 people Coast-wide in physical activity; the implementation of new HEHA polices within DHB premises as a role model for others in the community; ongoing participation in. • Active West Coast (a collaboration of groups/organisations trying to get more West Coasters more active more often); ongoing delivery of the Appetite for Life programme (a 6-week programme designed to assist women Coast-wide with the long-term objective to help them to achieve self-motivated healthy, active lifestyles); and the delivery of the "Spring into Action" Challenge programme. • The "Spring into Action" programme this time involved over 1500 people Coast-wide in physical activity (including over 500 children) over a six-week period for adults/four-week period for children, between May and June 2006. [Our 2005 "Spring Into Action" programme was named as a finalist in the New Zealand Health Innovations awards for 2006. • The 2005 programme also saw the West Coast DHB win the award in the large organisation category in the Push Play Activity Friendly Business Awards in December 2005 for best physical activity workplace initiative].
Reorient health services to promote healthy eating and healthy action	• Nutrition and physical activity is a core focus of the WCDHB health promoting health service programme. • The WCDHB health promoting health service programme extends to the DHB-owned primary care practices and invites other primary care practices to participate. • Continue to promote green prescriptions as an alternative, but effective way to promote the health of patients and their families and Whanau.	• This was maintained. • This is still progress. • This was continued.
Monitor, research and evaluate	• Evaluate programmes and initiatives, particularly new programmes, for effectiveness and reach. • Adapt programmes as necessary based on feedback.	• An evaluation programme for Spring into Action was undertaken this year. • Further development and adaptation will occur during 2006/2007.
Priority - Public Health		
Reduce the prevalence of smoking in the West Coast population.	• Implementation of West Coast PHO Smokefree Plan. • Continue to support health promotion and related services which aim to help people quit smoking and enforce Smokefree Environments Act. • Participate in events leading up to World Smokefree Day with health and	• Implementation of new Smokefree initiatives within District Health Board premises was achieved. • This was done. • This was done.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	other sector agencies. • Continue to provide hospital-based smoking cessation services. • Quitline data – number of West Coasters calling the service (Source: The Quit Group).	• This was done. • Data on this is not currently available.
Priority - Minimising Harm From Drug and Alcohol Abuse		
Minimise the harm caused by drug and alcohol abuse **Continue Intersectoral collaboration in identifying and treating those at risk of harm caused by alcohol and other drugs.**	• Continue to support LOAD as an effective working forum for Intersectoral collaboration and projects which arise. • Encourage use of the Alcohol and Drug helpline through increasing community and service user awareness of the service. • Ensure at least 50% of all patients over the age of 14 years registered with the PHO, have a documented alcohol history in units of alcohol per week / maximum single weekly dose. • Provide for small number of residential beds in newly developed rehabilitation model to support clients in their recovery. • Support and contribute to the development of an Intersectoral strategy aimed at minimising AOD issues in young people on the West Coast. • Increase brief interventions in primary care settings. • Review health education and screening in relation to respiratory and other diseases resulting from cannabis use. • Continue to provide a range of alcohol and drug services [including methadone]- improve accessibility to Maori. • Improve the responsiveness of mainstream AOD services to Maori. • Support other providers in the provision of drug and alcohol services. • Contribute to regional project in relation to the provision of and access to methadone services and implement recommendations. • Strengthen consumer participation in service planning and delivery.	• LOAD is recognised for its contribution to West Coast AOD service development and inter service collaboration. • The use of the AOD helpline continues to be promoted to service users. • Beds will be provided in new rehabilitation facility to assist people with AOD issues to recover. • This was achieved through the regional AOD initiative. • Education on AOD [incl Methadone] issues has been provided to primary health practitioners during the year. • A new contract with the MOH will enable full physical health screening for clients of the Methadone service. • Dedicated Maori mental health input available for AOD service but will be reviewed this year to determine need for an increase. • Inter agency service development group is being established to provide strategic planning for AOD services over the next five years. • Strong consumer input into AOD service planning continues.
Priority - Minimise Family Violence, Child Abuse And Neglect		
Plan and Implement Family Violence Prevention Programmes.	**Violence is internationally recognised as a key public health issue. Child abuse, sexual violence, partner abuse, elder abuse and school bullying, are all preventable forms of health harm and social disruption.** • Create a 'can do' culture in responding to victims of family violence.	• DHB project plan & timeline completed and includes: Staff training - Initial staff training programme created. - Eligibility criteria for National FV training partially completed. - Staff training due to commence for

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	• Develop a DHB Family Violence Project Plan and report on progress. • Ensure DHB staff are trained in the use of the Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse. • Ensure internal documentation and referral procedures, are implemented and monitored. • Participate in Intersectoral community initiatives to address family violence. • Continue to participate in the Evaluation program run by the Auckland University of Technology (AUT), and sponsored by the Ministry of Health. • POP-07 Planning and Implementing Family Violence Intervention programmes.	Emergency department & Parfitt staff November 2006. Documentation - Family Violence Policy & Domestic Violence procedure circulated for feedback. - Child protection procedure under development. • Family violence steering committee convened May 2006. Committee Terms of Reference currently at CEO for sign off. • WCDHB convened & facilitated forum regarding Elder abuse 24 July 2006. • AUT Audit scheduled to commence in September 2006. • Family Violence Programme introduced and evaluations collected from hospital staff.
REGIONAL AND NATIONAL HEALTH EMERGENCIES		
The West Coast DHB will continue to contribute to the development of any new national plans for health emergencies that may be developed by the Ministry of Health.		• The DHB continues to work towards further development of integrated health emergency planning with other agencies, including territorial authorities. It remains committed to participation in the development of the West Coast CDEM Plan. The DHB does have a major incident plan to ensure that an appropriate state of readiness is maintained. • The West Coast DHB will also provide as part of its annual budget, a contingency (0.1% of total budget) fund to cover the cost of any services purchased in relation to a major incident. • Ongoing training throughout the next year is planned for staff in understanding and structure of the Coordinated Incident Management System. Senior management are participating in planning with MOH in February 2005. • Further development and upgrading of the West Coast DHB Emergency Plan will continue throughout 2005/06.
Implementation of the National Health Emergency Plan: Infectious Diseases		• Participation in regional and national exercises has occurred when required (e.g. during the avian flu pandemic preparation process).
IMPROVING ELECTIVE SERVICES		
Elective Services Performance Indicators (ESPI)	The West Coast DHB remains committed to the basic principles of the elective services policy of clarity, timeliness and fairness.	ESPI compliance not achieved at 30 June 2006 however significant improvement has been shown throughout the 2005/06 year. An ESPI Recovery Plan is in place for the 2006/07 year that will see compliance achieved across all specialties by 30 September 2006.
Continuous Quality Improvement	Work has been undertaken in the CQI framework established under the orthopaedic initiative and will be rolled out to	• Some of the actions contained within the OI P&E Plan were not achieved at 30 June 2006 however in many cases this is the result of evolution of the

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
(CQI)	other specialties.	service through other CQI activity. Much of the work undertaken in orthopaedics has had a positive impact on the secondary service as a whole. It is expected this work will continue through the 06/07 year.
Volumes	Within the financial resources available, the West Coast DHB purchases sufficient inpatient surgical volumes through its provider arm to ensure patients in clinical need are able to access elective surgery so they avoid unreasonable distress, ill-health and incapacity; particularly those in need of urgent and semi-urgent treatment.	• Annual purchase volumes are based upon historical throughput, with adjustments made according to relative demand on individual specialties. Purchase volumes and waiting lists are both regularly monitored, and funding is moved across specialties during the year to meet inpatient demand pressures wherever possible within funding constraints. • As well as the core elective surgical services provided by resident specialists, the West Coast DHB provides complementary surgical services, including urology, plastic, specialist paediatric surgery and dental surgery, on a visiting specialist basis. Such services are provided via collaborative and cooperative arrangements with other DHBs or private health providers, i.e. Urology Associates, Mobile Surgical Services Bus, Ophthalmology. • Annual volumes are adjusted to reflect areas of need. • West Coast DHB is endeavouring to hold our current level of volumes within a reduced PBF. Within the current holding pattern we are not readily available to increase our volumes. However, the ability to trade within PBF will create an environment for inter district flows of work back to the West Coast. This approach will provide opportunities to: • Improve greater benefits to patients as the health service needs are provided on the Coast rather than the need to travel great distance to access health services. • Increase use of our capacity, within theatre, wards and overall hospital space utilisation. • Reduce our costs of IDFs, reduction in travel and accommodation expenditure for patients needing to travel.
Productivity	As part of the orthopaedic initiative, increased productivity will continue in 2005/06 with additional joint volumes being undertaken. In addition, any opportunities to further increase productivity will be actioned and reported to the Board.	• A CQI Facilitator for both the Orthopaedic and Cataract Initiatives was appointed late in 2005. • Close contact will be kept with the West Coast DHB MOH key electives contact, and critical issues discussed. • A Productivity and Efficiency Plan for the 05/06 year for the Cataract Initiative was developed and approved by MoH. The CI P&E Plan has a more strategic focus as the service is provided by visiting consultants. • Additional volumes required in 05/06 for both Initiatives have been exceeded. • A Liaison Committee has been established and the process of development of local referral guidelines has begun. • Trade-offs between services will continue to be undertaken on a regular basis, ensuring services

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
		with increased need have that need recognised where appropriate.
Consistent Prioritisation	All West Coast DHB elective services are using consistent prioritisation tools and processes.	• Achieved as evidenced by continuing compliance in ESPI 8. • Booking staff in outpatients and theatre have been provided with education on booking requirements in line with electives policy and regular interaction between booking staff and internal elective services contacts continues. • Scatterplots received from MOH are regularly reviewed by both management and clinicians, with specific attention being paid to any anomalies. Theatre booking staff have a mandate to ensure that patients are treated in priority, ensuring that any clinical over-ride is documented within the PMS for future audit. • The West Coast DHB is committed to ensure that all patients are seen within a 6-month period for first assessment. This objective is reliant on the West Coast DHB having and maintaining a full complement of clinical staff and the availability of visiting specialists.
ACC Data Coding	The West Coast DHB is committed to improving the data quality in regard to ACC data coding.	• The West Coast DHB data quality has slipped in the last year. Ongoing staffing difficulties in a number of areas have contributed to this. • We are committed to improving this in the very near future, along with the planned introduction of e-lodgement for ACC 45's.
Elective Services and Waiting Times – Continuous Quality Improvement	Within the financial resources available, the West Coast DHB purchases sufficient inpatient surgical volumes through its provider arm to ensure patients in clinical need are able to access elective surgery so they avoid unreasonable distress, ill-health and incapacity; particularly those in need of urgent and semi-urgent treatment. Following assessment, specialists manage the care of those patients requiring routine procedures, either treating them within the purchase volumes or referring them back to their GP for ongoing care and review.	• Annual purchase volumes are based upon historical throughput, with adjustments made according to relative demand on individual specialties. Purchase volumes and waiting lists are both regularly monitored, and funding is moved across specialties during the year to meet inpatient demand pressures wherever possible within funding constraints. • Actions have been identified in the ESPI Recovery Plan for compliance by 30 September 2006 that will assist in management of waiting lists and ongoing CQI activity in all specialties. • Difficulties persist in services provided by visiting consultants however significant work has been undertaken and is continuing at both strategic and operational levels to improve access and outcomes for patients referred to these specialties. • As well as the core elective surgical services provided by resident specialists, the West Coast DHB provides complementary surgical services, including urology, plastic, specialist paediatric surgery and dental surgery, on a visiting specialist basis. Such services are provided via collaborative and cooperative arrangements with other DHBs or private health providers, i.e. Urology Associates, Mobile Surgical Services Bus, Ophthalmology.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
Innovation	The West Coast DHB is currently seeking access to increased ophthalmology services at Grey Hospital, particularly in relation to cataract surgery. This service is currently only available via Canterbury DHB or the mobile surgical bus. It is our intention to pursue a collaborative arrangement with Nelson-Marlborough DHB in regard to this.	• Ongoing discussions with Canterbury DHB are still being progressed in regard a number of areas. This would has the potential to benefit both DHBs. • Contract for cataract surgery in place with a Nelson based provider. Visiting ophthalmologist providing services at Grey Hospital. • Development of local referral guidelines has commenced and innovative service delivery projects in General Surgery, Plastics and Ophthalmology are being discussed. • The West Coast DHB is also undertaking some analysis of interdistrict flow data to see if there is any surgery currently being performed in other DHB regions which we might well undertake locally. This would have the dual advantage of both reducing the cost and inconvenience to patients of travelling away for care, as well as maximising our own resource. This is ongoing with the GP's now engaged in the process.
Orthopaedic Initiative	The DHB will deliver the volume of joints (x10 additional) agreed to for 2005/06.	• Additional joint volumes agreed for 05/06 for both the OI and CI delivered. Targets were exceeded in both the OI and CI.
	CQI plans have been implemented and will continue to be implemented in a staged process throughout 2005/06 for both ESPIs and productivity/efficiency.	• CQI Facilitator appointed for both Initiatives to monitor volumes and activity on P&E Plans on an ongoing basis. • Plans will continue to be regularly reviewed with the OI Team and monitoring of progress will be undertaken on a monthly basis. • Regular meetings are held with key MOH electives contacts, and plans are agreed to ensure that these volumes are met.
Continuous Quality Improvement – Elective Services	Good progress has been made and maintained by the West Coast DHB in this area. We continue to work on: • the quality of data provided to the National Booking Reporting System (NBRS). • improving the prioritisation processes used. • consistent application of prioritisation processes. • ensuring treatment decisions are based on outcomes of prioritisation. • analysis of standardised intervention rates by DHB. • processes used to manage elective service patient flows, as measured by ESPIs.	• CQI activity has occurred across all specialties and will continue into the 06/07 year.
	The orthopaedic initiative will continue in the 2005/06 year and our expectations are that: • all clinicians should be using acceptable prioritisation processes.	• WCDHB's clinicians continue to be engaged in CQI activity including use of nationally recognised prioritisation tools. • Discussions are underway for registration of a local

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
	• all tools being used are registered with NZHIS. • clinicians will participate in CQI activities around prioritisation. • data will be recorded for each patient on their priority, eventual outcome, and a code for the responsible clinician. • surgeons will participate in improving consistency of access for hip and knee joint replacement.	tool in General Surgery.
Elective Service Performance		
Elective Services Performance Indicators (ESPI) Targets [SER 03] The Elective Service Programme endeavours to implement the goals of fairness, clarity and timeliness for patients who seek to access publicly funded elective services.	To achieve these goals requires prioritisation and equity of access. Providers are to accurately determine their capacity and advise patients accordingly Services are to be delivered within six months to those who can expect publicly funded services.	• An ESPI Recovery Plan was agreed for the 2005/06 year however compliance was not achieved at 30 June 2006. It is anticipated that compliance will be reached in September 2006 and a new ESPI Recovery Plan has been agreed on this basis.
ESPI 1 DHB services that appropriately acknowledge and process all patient referrals within 10 working days.	100% for all services.	• 100% for all services achieved.
ESPI 2 Patients waiting longer than six months for their first specialist assessment (FSA).	0% for all services.	• This target was not achieved during 2005/2006.
ESPI 3 Patients waiting without a commitment to treatment, whose priorities are higher than the actual treatment threshold (aTT)	Less than 5%, with the aim to be 0% for all services.	• Less than 5%, with the aim to be 0% for all services was achieved.
ESPI 4 Clarity of treatment status (number on the booking system without an assigned status	0% for all services.	• This objective was achieved.

Output	Performance Target to 30/6/06	Actual Performance to 30/6/06
appropriate to their priority and on residual waiting lists)		
ESPI 5 Patients given a commitment to treatment but not treated within six months	Less than 5%, with the aim to be 0% for all services.	• This objective was not achieved.
ESPI 6 Patients in active review who have not received a clinical assessment within the last six months	Less than 15%, with the aim to be 0% for all services.	• This objective was not achieved.
ESPI 7 Patients who have not been managed according to their assigned status and who should have received treatment	Less than 5%, with the aim to be 0% for all services.	• This objective was not achieved.
ESPI 8 The proportion of patients treated who were prioritised using nationally recognised processes or tools.	Greater than 95%, with the aim to be 100% for all services.	• This objective was achieved.

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 2005/06;

2005-06	2004-05	2003-04	
5,876	6,170	6,414	Patient discharges from hospital (raw inpatients /day patients purchased on a WEIS and non-WEIS basis)
3.47	3.36	3.48	Average length of stay (days) for medical and surgical patients
2,107	2,194	2,291	Total surgical operations performed in theatre **(1,651 of which were non-acute)**
17,972	16,370	16,746	Specialist outpatient attendances **(of these 5,597 were first attendances)**
12,179	12,870	12,431	Emergency Department attendances
54,477	56,883	54,588	Outpatient and domiciliary personal health attendances by allied health services (excluding X-ray, Laboratory, Special Area Medical Officer & GP Contacts, and Smoking Cessation).
8,075	7,975	8,869	Outpatient and domiciliary disability support attendances by specialist and allied health services
35,600	41,860	47,632	Meals on wheels were delivered Coast wide
11,959.75	11,376.5	13,275	Home help hours to personal health and maternity clients
308	282	289	Babies were delivered in hospital
4,585	4,659	5,183	Children served by school dental service
1,109	1,273	1,547	Children served by public health nursing service
28,488	28,299	28,978	Days of care for rest home and long stay patients **(plus 192 day care service attendances)**
4,635	5,804	7,549	Inpatient mental health days of care
22,359	21,560	22,692	Face to face attendances by outpatient and community mental health services (including CAMHS, A&D, Child & Youth, etc)
2,908	3,292	3,663	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;

2005-06	2004-05	2003-04	
1,037	1,012	1,017	**Number of people employed by the West Coast DHB (606.5 FTEs, as at 30 June 2006)**
$44m	$39m	$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 2006

	Board Budget June 2006	Board Actual June 2006	Board Actual June 2005
Revenue	1,070	1,046	1,117
Operating Expenses	(982)	(963)	(921)
Net Operating Surplus (Deficit)	88	83	196

Funding Operating Statement for the 12 months ended 30 June 2006

	Board Budget June 2006	Board Actual June 2006	Board Actual June 2005
Revenue	84,549	85,042	75,635
Expenditure			
• Personal Health	(60,504)	(58,980)	(52,601)
• Mental Health	(9,721)	(9,639)	(9,600)
• Public Health	(159)	(265)	(176)
• Disability Support	(11,858)	(11,246)	(10,175)
• Other Services	(1,070)	(1,035)	(1,061)
Net Operating Surplus (Deficit)	1,237	3,877	2,022

Provider Operating Statement for the 12 months ended 30 June 2006

	Board Budget June 2006	Board Actual June 2006	Board Actual June 2005
Revenue	60,143	59,043	53,018
Operating Expenses	(56,205)	(58,730)	(52,600)
Operating Surplus (Deficit) Before Depreciation, Capital Charge Interest & Non Recurring Items	3,938	313	418
Depreciation	(2,719)	(2,607)	(2,615)
Capital Charge	(1,600)	(1,106)	(948)
Interest Expense	(940)	(717)	(749)
Operating Surplus (Deficit) Before Non Recurring Items	(1,321)	(4,117)	(3,894)
Net Operating Surplus (Deficit)	(1,321)	(4,117)	(3,894)

Summary of Revenue and Expenditure by Output Class

	Provider	Governance	Funder	Eliminations	Result
Revenue	59,043	1,046	85,042	51,948	93,183
Expenditure	63,160	963	81,165	51,948	93,340
	(4,117)	83	3,877	0	(157)

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

The DHB has consulted extensively in during 2005/2006 with local communities (both geographic and communities of interest) during the development of the 2005-2015 District Strategic Plan, the WISE plan and Child and Youth Health Plans and has incorporated results of that consultation into the District Strategic Plan. This Plan identifies key health gain areas for the West Coast population upon which the DHB should focus its resources. The West Coast DHB has been consolidating this Plan during 2005-2006.

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

Fox Glacier Clinic officially opened on Friday 27 January 2006

STATUTORY OBJECTIVE	EXTENT TO WHICH IT HAS BEEN MET
To improve, promote, and protect the health of people and communities	**Primary Health** The West Coast PHO, established 1 October 2002, assists in meeting requirements and objectives of the Primary Health Strategy. **Oral Health** Extensive work was undertaken that was aimed to improve oral health outcomes for West Coasters during 2006. This included work to promote water fluoridation to West Coast councils; however this was rejected by public referendum in the Grey District and Councillor vote in the Westland District. A campaign was not advanced in Buller. WCDHB assisted Westland District Council regarding the establishment of a dentistry practice in Hokitika following the earlier closure of the sole private practice in the area. **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 included significant input into the planning of the Meningococcal B Vaccination Campaign which continued 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. **Chronic Conditions Care Management – Cardiovascular Disease, Stroke Care Management, Cancer Control, Respiratory and Palliative Care** Our 2005/06 District Annual Plan identified that the West Coast DHB would embark on several service development and planning group work-streams, around cardiovascular disease, stroke care management, cancer control, respiratory and palliative care services on the West Coast. Further work undertaken since the 2005/06 DAP was completed identified much commonality and many inter-related issues that cut across these various chronic conditions; such that a more holistic and comprehensive approach to planning service improvement and integration was more likely to produce better outcomes than was looking at the individual conditions in isolation. To this end, planning focus shifted to developing a comprehensive Chronic Conditions Care Management work plan that would overarch improving management and best practice principles for services on the West Coast, rather than a series of condition-specific working parties. The Chronic Conditions Care Management Plan was largely completed by June 2005, and is due to be finalized and presented to the DHB Board in early 2006/07 for review and approval. The Plan covers all stages of the health and illness continuum for people with chronic conditions in terms of optimizing a healthy environment; providing for at risk populations; managing the acute event; initial management (first six months) of a chronic condition; and the longer term management (over six months) of a chronic condition. Across each of these five major categories in the continuum, the plan looks toward improvement in the following seven elements over the next three years in the West Coast setting: healthy systems (organization of health care); community resources and policy; delivery system redesign; decision support; clinical information systems; self management; and equity in health including access to and outcomes of health care.

	Diabetes The LDT progressed work toward the implementation of the Integrated Diabetes Service Plan (completed by the LDT in April 2005) during early in 2005/06, covering various local approaches toward diabetes awareness promotion, detection and follow-up, and diabetes management. This Plan included work around a patient held record, retinal screening services, patient and provider surveys, shared databases, podiatry service referral protocols, annual pharmacy reviews, exercise and self-management programme, agreed referral guidelines between services, Maori community involvement, and evidence-based directions about diabetes detection. **Others** Numerous other examples are given in the Statement of Service Performance in this Annual Report.
To promote the integration of health services, especially primary and secondary health services	There has been significant progress in increasing liaison and integration between 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 maintain a Primary Health liaison position to further improve the integration between and within the West Coast primary and secondary sectors. West Coast DHB and the PHO continue to share collaborate information on a number of initiatives, including improvement of diabetes services, chronic disease management and cancer control.
To promote effective care or support for those in need of personal health services or disability support services	The development of service reviews including: • Consultation on the WCDHB District Strategic Plan • Chronic Conditions Management Plan • Integrated Diabetes Service Plan • Child and Youth Health Plan • West Coast Improving Services for the Elderly • Maori Health Plan • Primary Mental Health 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*** Tatau Pounamu has established a plan for consultation with local Maori which is to be undertaken in 2006/07. ***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*** The Maori Health Plan has been updated. 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 Tatau Pounamu, the Manawhenua Health Committee to the West Coast DHB. This group is made up of representatives from Nga Papatipu Runanga, and Rata Te Awhina Trust.
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 during 2005/2006 with local communities (both geographic and communities of interest) during the development of the 2005-2015 District Strategic Plan, the WISE plan and Child and Youth Health Plans 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 continues its community engagement and participation in service planning and where significant changes are likely. Statutory Committees of the Board have significant community representation. Public forums were held to discuss the Health of Older People and Reefton Health Services.
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) and a needs assessment of the Maori population is planned for 2006/2007.
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 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.