
# ANNUAL REPORT 2009-2010

WEST COAST
Te Tai o Poutini
Primary Health Organisation

# Contents



# 1. Trustees Report

Trustees take pleasure in presenting the Annual Report and Financial Statements for the year ended 30th June 2010.

The West Coast Primary Health Organisation (PHO) is a not-for-profit charitable Trust which is funded, through a variety of contracts by the West Coast District Health Board and other organisations, for a range of primary health care services to the people of the West Coast enrolled with a medical practice. These include not only first line services to restore people's health when unwell but a number of targeted programmes to improve access to health services and to maintain good health.

Trustees are drawn from community, Iwi and provider interests in the decision-making of the West Coast PHO. The Chief Executive's report highlights the progress and gains in a number of services consistent with our various contractual obligations.

Our relationship with the West Coast District Health Board (DHB) continues to be a mature, confident and growing partnership. In February of this year the West Coast PHO and the West Coast DHB jointly prepared and agreed to ***"Business Case - Better, Sooner, More Convenient Primary Health Care"***. That business case expressed a commitment by both organisations to a clinically and financially sustainable and enduring service model for the West Coast by integrating a number of services, particularly general practice, community nursing, needs assessment, allied health and mental health services. It was pleasing that this proposal has been endorsed by the Ministry of Health. Implementation is now underway.

The West Coast PHO has a Clinical Governance Committee as an advisory committee to the board. Its role is to assist the Board by providing advice on:

- the clinical components of all programmes, services and interventions undertaken by or contracted by the PHO;
- professional development for PHO contracted providers;
- workforce arrangements necessary for clinical programmes to meet specified outcomes.

The Board is appreciative of the work done by the Committee and in particular its Chair, Dr Greville Wood, and the PHO's Clinical Advisor, Dr Jocelyn Tracey.

The West Coast PHO concluded the year with a deficit of $46,932.

As Chair, I am grateful to the Board of Trustees for their contribution to the West Coast PHO which continues to function in a dedicated and effective manner.

The attendance of Trustees at Board meetings is as follows:

| | |
|---|---|
| John Ayling (Chair) | 6 |
| John Boyse | 7 |
| Tony Coll | 7 |
| Anna Dyzel | 5 |
| Helena Evers | 6 |
| Maureen Pugh | 7 |
| Tim Rochford | 5 |
| Rosalie Sampson | 6 |
| Tamai Sinclair | 4 |
| Richard Wallace | 2 |

The Annual Report also provides an opportunity to acknowledge the contribution made by Ms Andrea Baker who tendered her resignation as CEO in November 2010. Since that time the PHO has retained the principals of *PHOcus on Health* to provide management and professional advice on clinical services. Finally, acknowledgement needs to be made of the significant contribution made by staff of the PHO-they are a great team.

The PHO is reliant on many individuals and groups within the health sector. Without their continued support our efforts in achieving the results we are reporting would not be possible. We record our thanks to them for this commitment.

For and on behalf of the West Coast Board of Trustees

John Ayling
**Chair**

# 2. Management Report

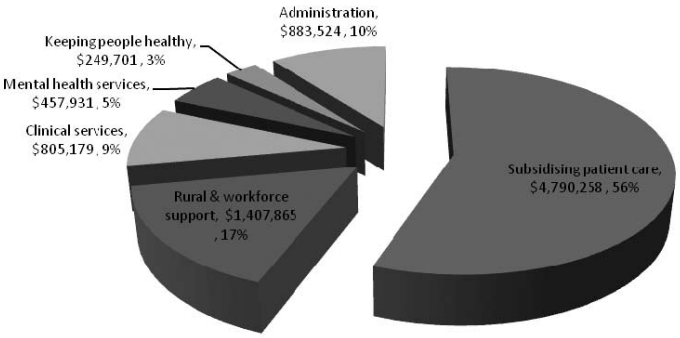
The West Coast Primary Health Organisation works in two principal ways:

1. It provides funds to, and otherwise supports, the provision of primary health care, primarily through the region's medical centres (or general practices), and

2. It directly provides some primary health care services itself, again in ways that work in with, and support, the efforts of the general practice teams.

Its money is spent in the following areas and proportions:

**WCPHO Expenditure**




On average, the PHO had 30,456 patients enrolled via the medical centres up and down the West Coast.

All eight general practices on the West Coast, from Karamea to the Haast, are contracted to the West Coast PHO and all of these practices remain Very Low Cost Access (VLCA) practices, which means ongoing lower medical and pharmaceutical costs to the community.

The following table shows the patient co-payment for a standard visit to the GP within normal office hours during the 2009-10 financial year:

| | |
|---|---|
| Under six | $0 |
| 6 to 17yrs | $11.00 |
| Adults | $16.50 |

The PHO subsidised 122,254 visits by enrolled patients to its contracted medical centres during the year[1]. This was up from 119,933 visits during the previous twelve months (a 2% increase).

This represents an average of four visits for each enrolled patient in the PHO. The average subsidy for each enrolled patient was therefore $176.95 (incl. GST) during the year. The average subsidy per patient visit was $44.08 (incl. GST).

A major challenge is the severe shortage of, particularly, general practitioners living and working permanently on the West Coast. This too often results in delays for patients wanting to access primary care. It also places considerable strain on those GPs and other clinical staff members who

are dedicated to the West Coast. But, despite this shortage, the number of patient visits that occurred is on a par with many other parts of New Zealand, and is a testament to the hard work and dedication of general practice teams.

A major strand of work for the PHO during the past year has been responding to the Ministry of Health's request for expressions of interest in providing 'better, sooner, more convenient primary health care'.

The PHO was successful in its application (along with eight others across NZ, out of more than 70 applicants), and then had to develop a detailed business case setting out how it planned to achieve the Ministry's revised expectations. This involved a great deal of collaboration and negotiation with the DHB, with practices and other providers around the West Coast. The vision is built around taking a 'whole-of-system' approach to the health sector, and tackling the key, systemic issues we face.

1 this does not include visits by enrolled patients for accidents, which are funded by ACC, and nor does it include visits by patients who were not enrolled in the PHO, or who were enrolled but attended a different practice to their usual one.

The major drivers for change are:

- Clinical sustainability: the current model of care in most health centres requires GP numbers we have not been able to achieve consistently on the West Coast for at least five years, and leads to long waiting times for appointments (often greater than three weeks) and lack of continuity and consistency of care.
- Limited integration of community services with primary care leading to lack of co-ordination and consistency of care and some duplication of services.
- Financial: primary care medical practices and community services owned by the DHB contribute significantly to the DHB overspend each financial year.

Increasingly, the West Coast and Canterbury DHBs will be working more closely together, particularly in terms of the sustainability of secondary services and of Grey Base Hospital. This represents a rich opportunity to progress the primary care business case, and develop a more robust primary care system. Our primary care system is currently reasonably effective, but vulnerable. It will be important that the transformation and development of a more robust primary care system is done in a fashion that ensures it is well connected with the secondary/hospital system, both on the West Coast and in the rest of the country.

Finally, we'd like to record our thanks to all the hard working and imaginative staff of the PHO, to the Trustees, to the general practice teams and to other colleagues throughout the West Coast health system.

Anthony Cooke
Chief Executive

Dr Jocelyn Tracey
Clinical Director

# 3. Subsidising Routine Access to Primary Care

## Aim
To improve access to primary health care services by reducing the cost that patients pay each time they visit their medical centre.

## Target group
All people enrolled in the PHO.

## Key activities
- To pass on the funding for "first level services" to contracted practices, so that patients do not have to pay the full cost of their visits to the general practice.

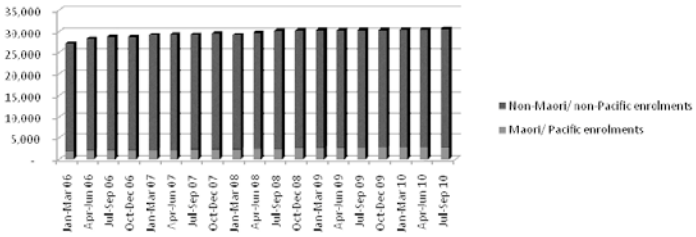
## Progress in 2009-2010
- During the course of the year all general practices remained Very Low Cost Access (VLCA), which maintained the lower per-visit payments patients had to make.

## Cost of co-payment during 2009-10

| | |
|---|---|
| Under 6 yrs | $0 |
| 6 to 17 yrs | $11.00 |
| Adult | $16.50 |

## Outcomes measured
On average, the PHO had 30,456 patients enrolled during the financial year. The number of enrolled patients increased slightly from 30,402 during the first quarter (Jul-Sep 09) to 30,548 during the last quarter (Apr-Jun 10).

### Enrolments of West Coast Residents by Ethnicity




The PHO subsidised 122,254 visits by enrolled patients to its contracted medical centres during the year[2]. This was up from 119,933 visits during the previous twelve months (a 2% increase).

This represents an average of 4 visits for each enrolled patient in the PHO. The average subsidy for each enrolled patient was therefore $176.95 (incl. GST) during the year. The average subsidy per patient visit was $44.08 (incl. GST).

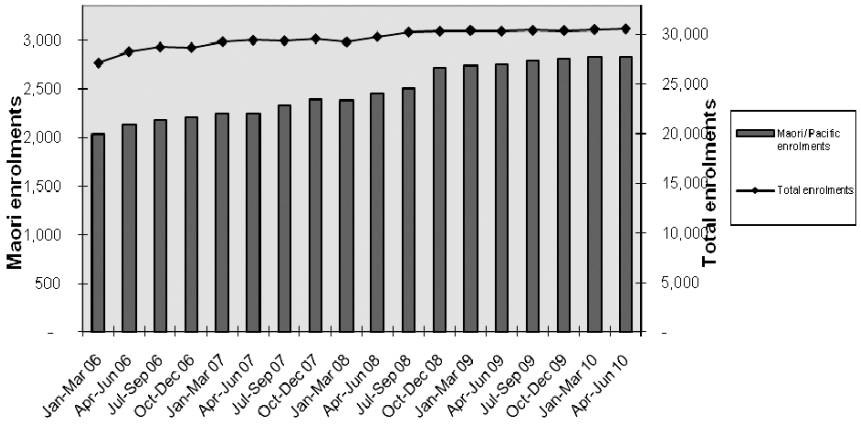
## Expenditure
$4,790,258 (cf. $4,506,811 previous year)

2 this does not include visits by enrolled patients for accidents, which are funded by ACC, and nor does it include visits by patients who were not enrolled in the PHO, or who were enrolled but attended a different practice to their usual one.

## 3.1 Access for Maori

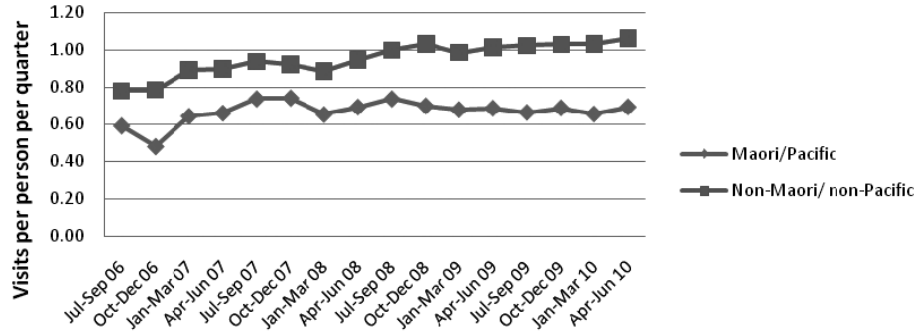
Over the past eighteen quarters, enrolments in the PHO by Maori and Pacific Island people have grown 40%, while those by people of all other ethnicities have grown 10%.

### PHO Enrolments




Maori and Pacific people still tend to visit the doctor less often, than non-Maori and non-Pacific people, though this may be partially explained by the typically younger age profile of Maori and Pacific peoples.

### Rates of Visits Each Quarter



# 4. Clinical Programmes and Services

## 4.1 Long Term Conditions (LTC) Management

### Aim
To improve health outcomes and reduce inequalities for people living with a long term condition (chronic disease).

### Target group
All patients with cardiovascular disease, diabetes, chronic obstructive pulmonary disease or a combination of these.

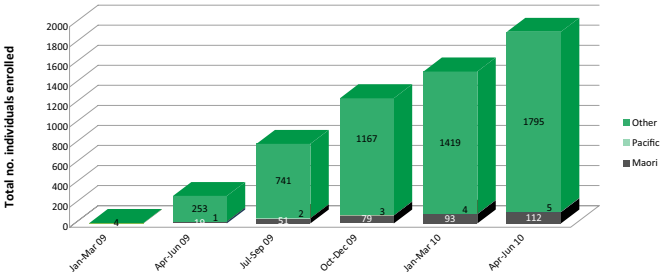
### Key activities
General practice teams have been using the LTC programme since April 2009, with the following aims:

- To stratify individuals into one of three levels of care depending on the complexity of their health problem and ability to self-manage their condition;
- To provide an in-depth annual review for each condition and then receive a package of care based on level of need;
- To provide a jointly developed care plan called 'My shared Health Record' for each patient;
- To refer patients to other PHO programmes or community support programmes as required.

### Progress 2009-2010
- All practices are enrolling patients into the LTC Management programme.
- Training and support to the practice teams has continued throughout the year.
- Flinders 'Partners in Health' full training was provided for two Rural Nurse Specialists in April to help support patient self-management and the LTC Management programme.

### Outcome achieved
- In total, 1655 enrolments have been made into the LTC programme this year: level one, 1312; level two, 310; level three, 33.
- Enrolments are made up of 6% Maori and 94% Other ethnicities.
- The following graph shows the number of people enrolled since the programme began:

**Enrolments in the long term conditions programme**




### Source of funding
Services provided as part of the LTC group of programmes are funded by Care Plus, Diabetes Annual Review, Services to Improve Access and a specific DHB contract for Level 3, Smoking Cessation and Healthy Lifestyles funding streams.

### Expenditure
$440,718

## 4.1.1 Screening for Cardiovascular Disease and Diabetes

### Aim
To identify patients at high risk of having a heart attack or similar poor health outcome, or at risk of diabetes, and to work with these patients to decrease their risk.

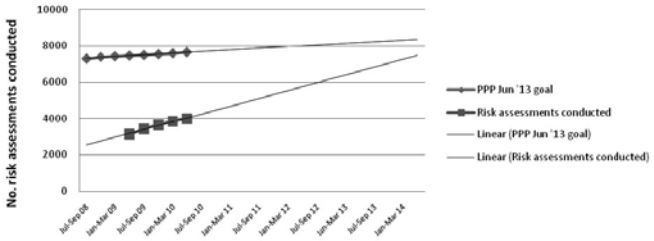
### Target group
All individuals recommended for screening by the national Assessment and Management of Cardiovascular Risk guideline, with particular emphasis on high needs groups including Maori and Pacific.

### Key activities
- To screen all eligible individuals for cardiovascular risk and diabetes over a five year cycle;
- To identify individuals who are at greater than 15% risk of having a heart event over the next five years, or with diabetes or pre-diabetes;
- To ensure that these individuals are on the most appropriate treatment regimes;
- To link these individuals with lifestyle support programmes provided by other community groups and primary care providers;
- To ensure that individuals at high risk have an annual assessment of their risk level;
- To decrease smoking, blood pressure, lipid levels and body mass index (BMI) and hence overall cardiovascular risk in these individuals;
- To decrease inequalities in treatment and in outcomes between high needs groups and the rest of the population at high risk.

### Progress 2009-2010
- This routine screening is available at all practices and rural clinics; either a General Practitioner or Registered Nurse can provide this service.
- Many people with high risk are referred on to Green Prescription to help them become active, and to smoking cessation services.
- A focus this year in conjunction with our Men's Health Forums has been to concentrate on 'hard to reach men' who have not had a CVD screen.

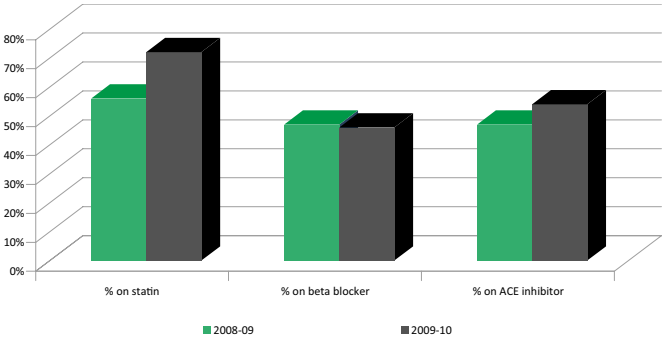
### Outcomes achieved
- 1561 screens were completed in the 2009-2010 year. Risk assessments include all initial screens, immediate follow-ups for high needs and non-high needs individuals, and annual risk assessment reviews.
- 42% of the eligible population have now been screened.

**Progress towards risk assessing the indicated WC population**




- During the year 5% of all risk assessments completed were for Maori.
- Of those assessed during the year, 15% were identified as having a five year cardiovascular risk level of 15% or greater.
- 80% of those screened were not smoking.
- The condition most commonly identified during the cardiovascular risk assessment process was metabolic syndrome.
- The following graph shows the % of high risk patients followed up for one year who are on a preventative medication:

**% patients at high risk of a CVD event on relevant medications**



## 4.1.2 Diabetes Care

### Aim
To improve health outcomes and quality of life for all people with diabetes.

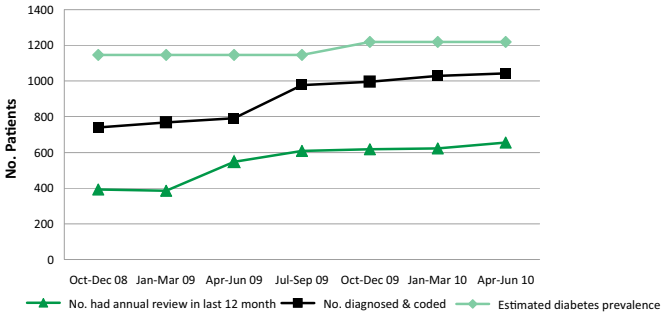
### Target group
All patients with diabetes.

### Key activities
- To provide an annual review for patients with diabetes;
- To review both clinical management and self-management of the patient's condition;
- To organise retinal screening clinics on the West Coast for people with diabetes;
- To assist individuals living with diabetes and their family/whanau to achieve better self-management of their condition;
- To support practices to ensure that as many patients as possible benefit from this programme, through regular reports to practices on the reviews and on health outcomes for patients;
- To review and address inequalities in delivery outcomes.

### Progress 2009
- Diabetes annual reviews are now a well established part of the Long Term Conditions Management programme.
- Preparations are underway for practices to use the new diabetes advanced form 'Get Checked II'.
- Practices receive quarterly reports on annual review activity.
- Practice teams are using nurse-led clinics for diabetes annual reviews.
- All practices are now performing diabetes annual reviews.

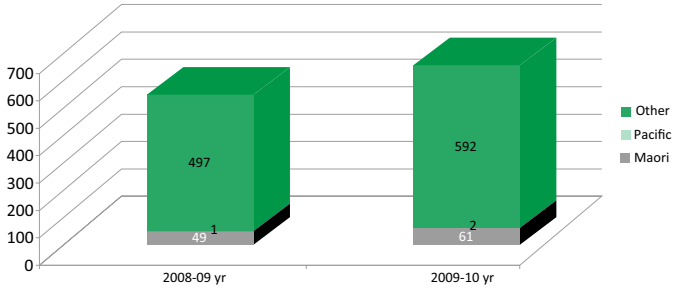
### Outcomes achieved
(Clinical indicator reporting, under this contract, is from January to December)
- 698 reviews were completed this year compared with 672 in 2008, still falling short of our target of 65% of annual reviews completed (these were for all ages).
- Maori smoking rates have continued to decrease: from 35% in 2008 to 26% in 2009.
- The target of up-to-date retinal screening for 85% of patients was not met, with 73% of patients being screened within the last two years. Despite this, the service provided to patients is of extremely high standard.
- The following graph shows the number of annual reviews completed; the number of people diagnosed as having diabetes; and the estimated diabetes prevalence, over the last 21 months:

**Diabetes prevalence, detection & clinical review**



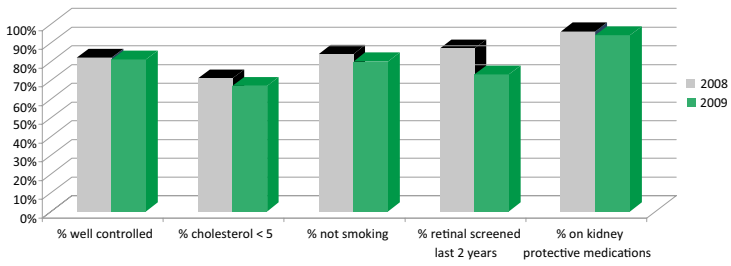

- The following graph shows the number of annual reviews over the last 2 years:

**Diabetes Annual Reviews**




- This final graph compares the clinical outcomes for reviews over the last two years:

**Clinical Outcomes for Diabetes Annual Reviews Conducted**




### Diabetes Self-Management Education Courses
It is well established that people living with diabetes provide most of their own care. As part of the Long Term Conditions Management programme, the Diabetes Self Management Education (DSME) course aims to enable people with diabetes to self-manage their conditions. The DSME courses provided by the PHO are designed to improve individual (and family/whanau) knowledge, self-care skills and self-confidence whilst living with Type II diabetes. In 2009 (calendar year), two facilitators delivered five courses in the following centres: Ngakawau (1), Greymouth (2) and Hokitika (2), with a total of 31 people attending overall.

## 4.1.3 Cardiovascular Disease Annual Reviews

### Aim
To enhance the management of cardiovascular disease (CVD), with particular emphasis on helping high needs patients (Maori, Pacific, and socio-economic deprivation decile 9 and 10).

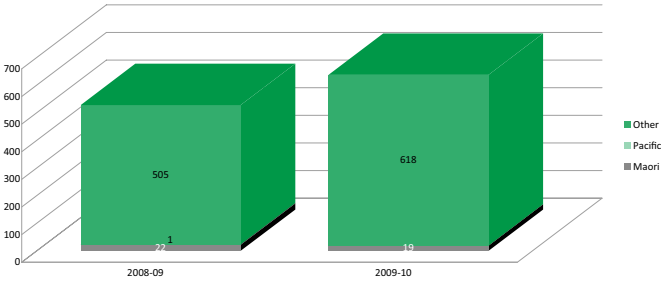
### Target group
All patients with established cardiovascular disease. This group encompasses the following diagnoses: angina, myocardial infarction, peripheral vascular disease, post revascularisation, ischaemic stroke or transient ischaemic attacks.

### Key activities
- To identify all patients with cardiovascular disease (CVD);
- To provide an annual review for all enrolled patients with established CVD;
- To reduce inequalities in treatment provision and health outcomes between high needs groups and the rest of the population with CVD;
- To ensure that these patients are receiving the most appropriate treatment regimes;
- To support these patients to self-manage their condition more effectively by providing opportunities for collaborative care planning and goal setting;
- To link patients with lifestyle programmes that can support them to make any required behavioural changes-either PHO based, provided by primary or secondary health care, or provided in the wider community.

### Progress 2009-2010
- CVD annual reviews are a routine part of the Long Term Conditions programme. Patients are receiving individualised care based on their clinical needs as well as their ability to self-manage their condition.
- Almost all practices, including rural clinics, are now carrying out CVD annual reviews.
- Practices receive quarterly reports on their CVD activity.

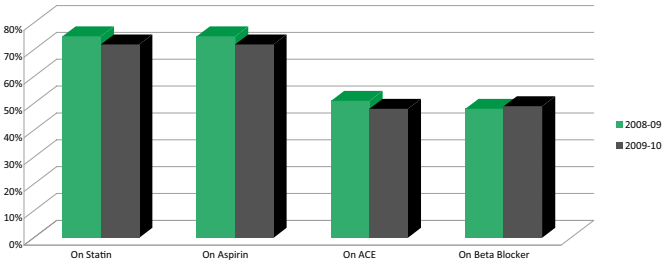
### Outcomes achieved
- 637 annual reviews were completed in the 2009-2010 year.

**CVD Annual Reviews**




- Myocardial infarction and angina made up 67% of all conditions identified as part of the clinical history of those having a cardiovascular annual review.
- Of the 637 people receiving a cardiovascular annual review, 72% were prescribed a statin, 72% Aspirin, 48% an ACE inhibitor, and 49% a beta blocker.
- The following graph show the percentage of people reviewed on preventative medication over the last 3 years:

**Percentage CVD patients on relevant medications**



## 4.1.4 Chronic Respiratory Disease: COPD Annual Reviews

### Aim
To improve the quality of life and encourage self-management skills of people living with Chronic Obstructive Pulmonary Disease (COPD).

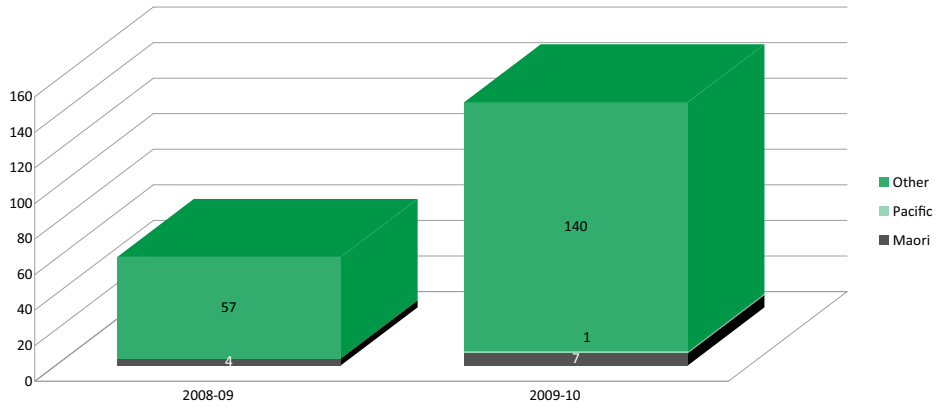
### Target group
All patients with COPD.

### Key activities
- To provide an annual review for all patients with COPD;
- To review both clinical and self-management of the patient's condition;
- To provide all COPD patients with an action plan to manage exacerbations;
- To support these patients to self-manage their condition more effectively by providing opportunities for collaborative care planning and goal setting;
- To link patients with other supports, services or programmes that can help them manage their condition - either PHO based, provided by primary health care, secondary health care, or provided in the wider community.

### Progress 2009-2010
- COPD annual reviews are now an established part of the LTC programme.
- Almost all practices are now carrying out annual COPD reviews.
- Practices receive quarterly reports on annual review activity.

### Outcomes achieved
- 148 annual reviews were completed in the 2009-2010 year.
- Of these reviewed, 83% had a flu recall made, and 74% have been given a COPD management plan.
- 5% screened were Maori and 95% other ethnicities.
- The average COPD admission rate per patient was 0.49 per year compared with 2.67 in January 2009.
- The average number of COPD exacerbations was 1.4 per patient this year compared with 5.67 in January 2009.
- The following graph shows the enrolments by ethnicity since the programme began in March 2009:

COPD Annual Reviews



## 4.1.5 Smoking Cessation

### Aim
To reduce tobacco smoking through increased availability and choice of smoking cessation services in the community.

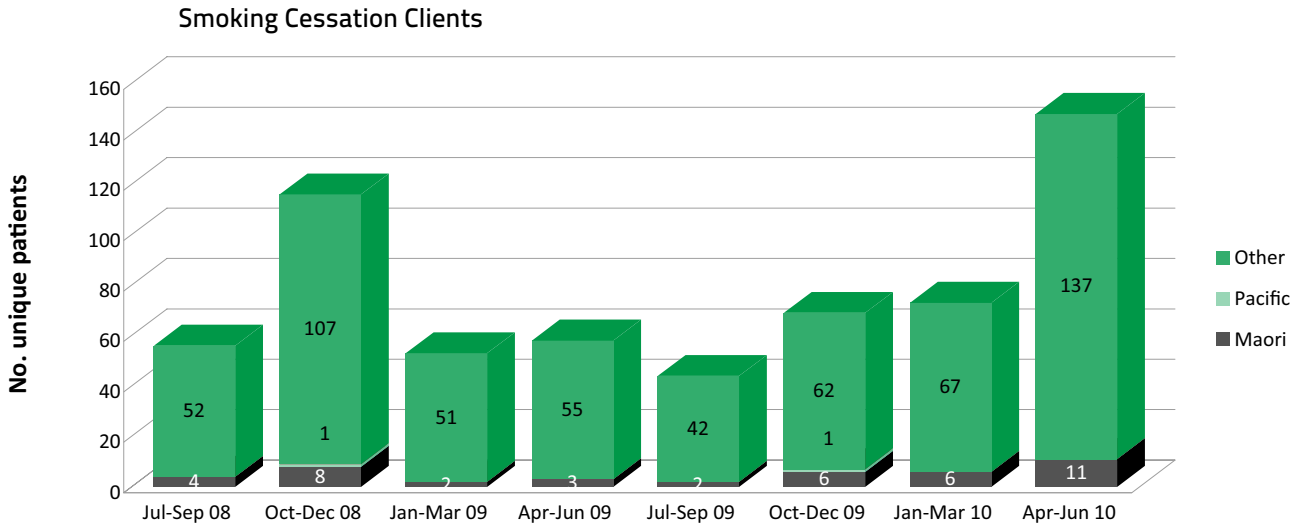
### Target group
All smokers on the West Coast, but particularly high needs groups.

### Key activities
- The Coast Quit smoking cessation programme is well established and is provided by nurses, GPs, rural nurse specialists, pharmacists and pharmacy staff across the West Coast;
- All practices are now recording smoking status for their patients;
- All practices are preparing to record the giving of brief advice and cessation support;
- Integration of all smoking cessation services on the West Coast to follow the ABC approach.

### Progress 2009-2010
- 2 Motivational Interviewing training days were held this year.
- 2 Coast Quit smoking cessation training days were held this year.
- 250 places on Coast Quit were available for the 2009-2010 year: enrolments exceeded this.
- Extensive promotion of 'Smokefree' May occurred in all practices and pharmacies on the West Coast.

### Outcomes achieved
- 334 people enrolled in this programme: 58% were female and 42% were male.
- Of the 334 enrolments, 7% were Maori.
- 23% enrolled with a local pharmacy, and 77% with a practice or clinic.

### Expenditure
$27,160




## 4.2 Contraception & Sexual Health

### Aim
To reduce pregnancy rates in the under 22 year age group and improve access to sexual health services.

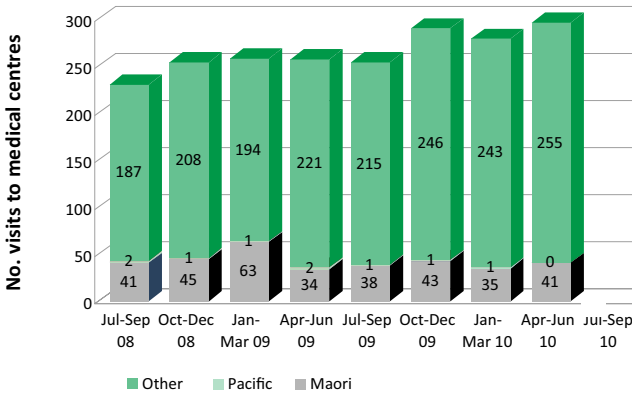
### Target group
Young people under 22 years of age requiring contraception (under 25 years for Franz Josef and Fox Glacier only).

### Key activities
- To remove financial and social barriers to accessing contraception and primary sexual health services for young people, particularly those at risk of ill health, injury and unwanted pregnancy;
- To ensure a wide range of access points to this service via provision at all practices and rural health clinics;
- Ensuring the service is accessible and acceptable to young Maori;
- To work actively with other providers of sexual health services, such as Rata Te Awhina Trust and the DHB as well as the community, to improve the reproductive and sexual health of young Maori.

### Progress 2009-2010
- The programme has embedded well this year, and continues to progress.
- 20 health professionals (GPs, nurses, independent midwives and public health nurses) attended the Introduction to Contraception training day in April.

### Outcomes achieved
- The number of individuals seen at practices this year increased by 120.
- The graph below shows the trend of increasing visits to practices over the last two years:

**Contraception & Sexual Health**




| | 07/08 | 08/09 | 09/10 |
|---|---|---|---|
| Prescription claims | 576 | 490 | 516 |
| Emergency contraception | 89 | 109 | 85 |

### Expenditure
$21,811

## 4.3 Corrections Vouchers

### Aim
To provide free acute care and general check-ups for clients of the Corrections Service, many of whom do not have a general practitioner.

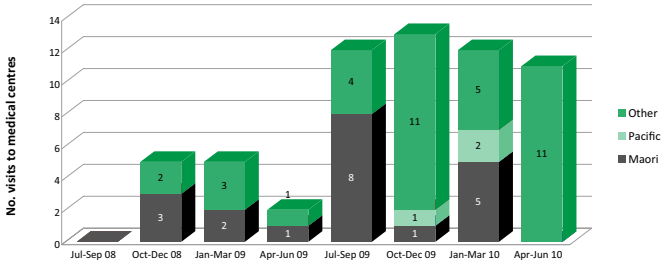
### Target group
Clients of the Corrections Service.

### Key activities
- Probation officers and community workers give vouchers that entitle high needs clients to free general practice care and prescription subsidies.

### Progress 2009-2010
- Promotion of the programme to Corrections staff has prompted an increase in referrals this year.
- This programme continues to benefit a very small number of high needs individuals.

### Outcomes achieved
- 48 contacts were made at medical centres this year, as shown in the graph below.
- 29% were Maori.

**Corrections Department Clients**




### Expenditure
$1,312

## 4.4 Palliative Care

### Aim
To reduce financial barriers for patients and their whanau receiving general practice care in the terminal stages of their illness.

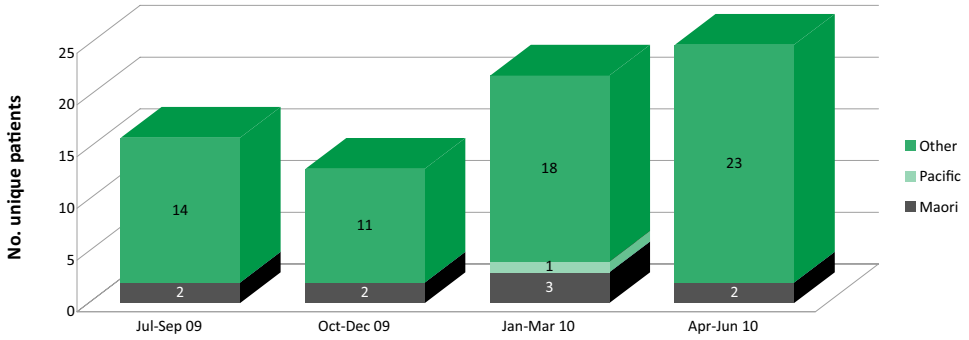
### Target group
Patients with terminal illness.

### Key activities
- Funding of terminal care clinics and home visits.

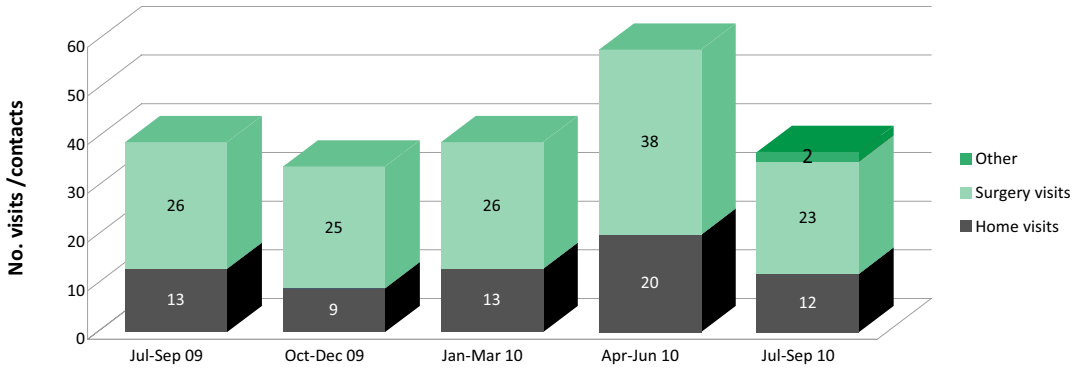
### Progress 2009-2010
- This programme covers the costs of visits to the general practice, home visits, and some part charges for medication used in a palliative setting for enrolled palliative care patients.
- An additional claim stream was added during the year: practices are now able to charge for virtual visits made on behalf of patients by palliative nurse specialists.

### Outcomes achieved

**Palliative Care Patients**




**Palliative Care Visits/Contacts by Type**



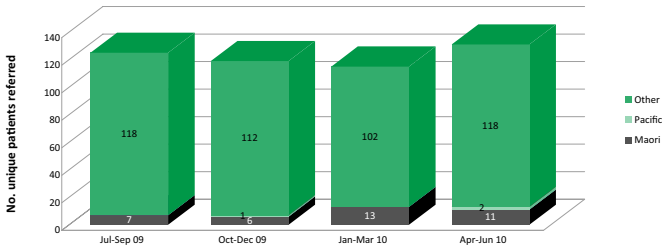

### Expenditure
$6,963

## 4.5 Mental Health

### Aim
To support West Coast General Practice Teams (GPTs) to improve health outcomes and quality of life for the enrolled population with mental health needs.

### Target group
Enrolled patients of West Coast practices, fourteen years of age and over, with mild to moderate mental health concerns.

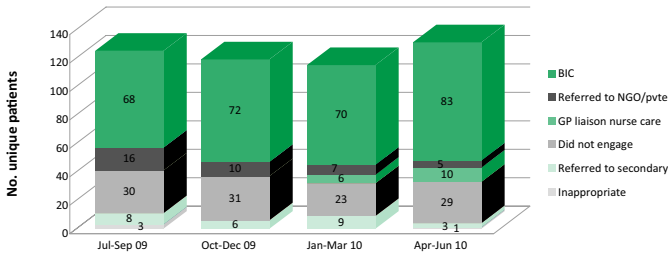
**MH Referrals for Assessment**



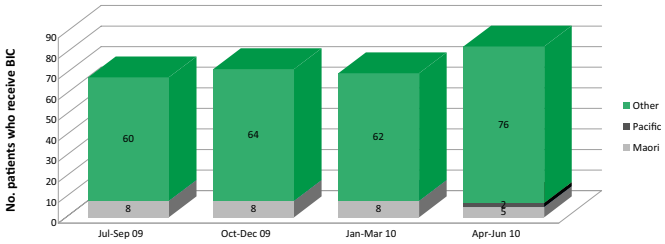

### Key activities
- The GP Liaison Nurse conducts formal or informal assessments and after consultation with the patient advises the requester (General Practitioner or Practice Nurse) as to the most appropriate pathway, one of which is Brief Intervention Counselling (BIC).
- Two psychologists and the Brief Intervention Counsellor provide up to six fully-funded sessions of BIC for those identified as meeting the specified criteria.
- Where people are aged under 18 years, a Primary Mental Health Team (PMHT) psychologist working with youth conducts the assessments, advises on referral pathways, and provides up to 10 sessions of BIC where appropriate.
- Extended Consultations, by GPs and PNs with enrolled patients who have mental health issues, are facilitated through the Mental Health funding.
- Education and support are provided to GPs and PNs in relation to mental health issues.
- Workshops and other assistance are given for primary health practitioners and other groups.

### Progress 2009-2010
- Ministry of Social Development beneficiaries were referred to the PMHT until the end of June 2009 and team members provided BIC (counselling) sessions for these people over much of the current year.
- Of the 490 requests received this year, 293 received Brief Intervention Counselling. Of these 228 were adults and 65 were youth.
- Presentations on several mental health topics were made to primary health practitioners.
- Orientation to the Mental Health Programme was provided for new GPs and PNs.
- A review of the Mental Health Programme by Dr Frances Hughes concluded that 'the service is providing a timely and effective primary mental health service to people with mild to moderate mental health problems.'
- A Mental Health promotional tool has been planned and prepared, for people undergoing BIC.
- Claims for Extended Consultations on mental health issues were received from all practices and totalled 237 for the current year - an increase of 117 over the previous year (120). Of the total, 182 were from GPs and 55 from PNs.

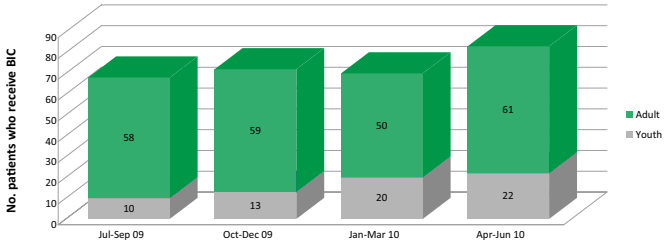
### Treatment Pathway Upon Referral



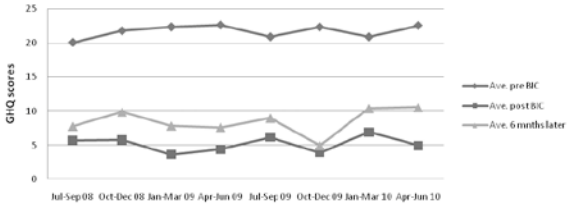

### Patients - Brief Intervention Counselling




### Patients - Brief Intervention Counselling




### Patient Outcomes (Change in GHQ Scores)




## Outcomes achieved

- Ministry of Social Development staff reported that 53% of all beneficiaries who had been referred to the team had entered training or employment, a significant and higher percentage than was usual with this group.
- General Health Questionnaire (GHQ12) measures taken before entering BIC, at the last counselling session, and at 6 months follow-up, indicate sustained beneficial changes from the Brief Intervention Counselling:
- On completion of counselling, over 99% of respondents confirmed that it was appropriate to receive counselling through the GP practices, and that they were very satisfied with the counselling.

## Expenditure

$412,155

# 5.Health Promotion Programmes

## 5.1 Health Promotion Community Activity

### Aim

To build health promotion capability, particularly in relation to advancing the Primary Health Care Strategy, and to implement collaborative projects.

### Target group

DHB, Community & Public Health, PHO staff and providers, NGOs, and the West Coast community.

### Key activities and outcomes, 2009-2010

- Men's Health Awareness forums with guest speakers were held at Hokitika, in conjunction with the 'Movember' promotion, and in Cobden. 80 men came to the forum in Hokitika, with 63 'hard to reach' and high needs men attending wellness clinics at the Westland Medical Centre, where 'WOF checks' included cardiovascular risk assessments. 35 men (17% were Maori) attended a wellness clinic at Nurturing the Future Hub in Cobden.
- Heart Week: all practices had displays and promoted this week. Local pharmacies had window displays (with the best winning a healthy morning tea), and a very large heart on the roof of High Street Medical Centre prompted media coverage. St John's ambulance service offered free blood pressure checks in Greymouth CBD; the local cardiac club had a community-promoted heart walk, and there was extensive advertising in local newspapers and on lockers at the Aquatic Centre in Greymouth.
- Smoke Free May: all practices and pharmacies across the West Coast participated, with staff wearing green smokefree T-shirts throughout May; in conjunction with the extensive promotion of smokefree at workplaces by C&PH and the DHB.
- Other community collaborative health promotion initiatives included 'walk to work day', 'Bikewise month', Daffodil Day, and the CCS Xmas Tree PHO display in all three districts.
- Influenza Vaccination Promotion: promotional visits at local supermarkets in Greymouth, Hokitika, Reefton and Westport, assisted by 'Rusty' the health promotion dog, dispelled myths and promoted the free vaccination to eligible people. The majority of practices held dedicated 'flu' clinics beginning in March. Extensive media advertising was undertaken across the West Coast.
- World Health Day was held at the Greymouth Aquatic Centre in conjunction with Grey District Council, C&PH, WCDHB, St John, Plunket Car Seat and Sports West Coast: 395 people attended throughout the day.
- Planning and preparation commenced for a Wellness Programme for Pike River Coal Mine staff.
- Healthy Lifestyle Ambassador Awards were presented to individuals in Westland, Grey and Buller districts.
- A health promotion road trip from Karamea to Franz Josef was undertaken to help support practices with health promotion ideas.

### Expenditure

$176,699

## 5.2 Green Prescription

### Aim
To improve health outcomes and quality of life for West Coasters by supporting and empowering them to exercise regularly as an integral part of their lives.

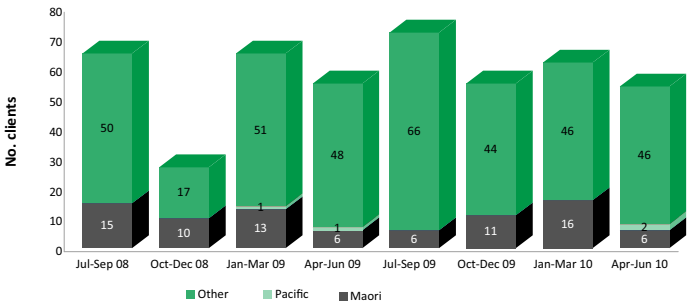
### Target group
All West Coasters 18 years of age or over who are inactive or at risk of developing diabetes and/or cardiovascular disease.

### Key activities
- Providing individual exercise programmes to enable people to exercise at home, achieved by an initial face-to-face visit and then supported by telephone follow-up over a four month period;
- A 10 week programme of individual or group exercise sessions at the PHO to familiarise people with gym equipment and for meeting other Green prescription patients;
- Community-based 'active you' group programme of eight weeks, aimed at getting people familiar with their community activity providers;
- Encouraging people to become independent with their own physical activity and to access local activity providers such as walking groups, the swimming complex, gyms, bowling club, etc.

### Progress 2009-2010
- Quarterly newsletters and Green Prescription updates sent to all practices;
- Negotiations and preparation to commence Green Prescription in Westport from September 2010;
- Commencement of the Active Living Youth Programme in April focusing on improved nutrition and increased levels of physical activity, and targeting at-risk and overweight/obese youth.

### Outcomes achieved
- 243 referrals were received in the 2009-2010 year.
- 16% of these referrals were for Maori - exceeding the target of 10%.
- The West Coast achieved nine out of ten KPIs from the Canterbury West Coast Sports Trust Green Prescription patient survey 2010, doing particularly well with key goals around increased physical activity, sustained behaviour change, and provision of high quality services and support.
- The following graph shows the number of Green Prescription clients over the last two years:

**Green Prescription Clients**




## 5.3 ACC Falls Prevention - Tai Chi and Otago Exercise Programme (OEP)

### Aim
To prevent falls in older adults through muscle strengthening and balance retraining exercise programmes, either Tai Chi group-based or OEP individualised in the patient's own home.

### Target group
People living at home who have had a previous fall, or are at risk of falling, aged 65+ years for Tai Chi or 80+ years for OEP.

### Key activities
- The modified Tai Chi programme is a group-based exercise course of 20 weeks (16 weeks from January 2010) duration to improve lower body strength, balance, postural alignment and concentration.
- The OEP programme is a 12 month home-based individually prescribed muscle strengthening and balance retraining programme.

### Progress 2009-2010
- Contract delivery variations for OEP and modified Tai Chi occurred in October 2009.
- No new participants were to start OEP from 1 January 2010, with the contract expiring in December 2010.
- Changes to Tai Chi included classes reducing to once per week for a period of 16 weeks, with the contract extended until December 2010.
- Tai Chi classes are very popular and are held in Greymouth and Hokitika.

### Outcomes achieved
- Total 20 participants from the two Greymouth classes, 100% NZ European;
- total 27 participants from Hokitika classes, 7% were Maori;
- 4 participants remaining in OEP programme as at 30 June 2010.

## 5.4 Breastfeeding Support

### Aim
To improve breastfeeding rates and create a supportive breastfeeding environment on the West Coast.

### Target group
Childbearing women and their families/whanau, particularly those in high deprivation and rural areas, young and Maori women, and health professionals.

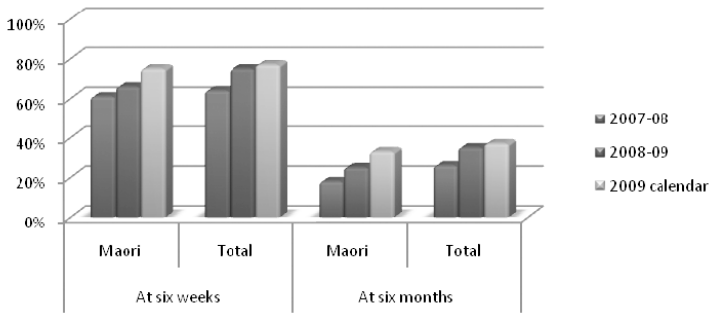
### Key activities
- Lactation consultancy;
- Peer counsellor (Mum4Mums) training and support;
- Breastfeeding education sessions;
- Networking and collaboration with the DHB, primary health sector and community;
- Community promotional activities, and advocacy.

### Progress and outcomes
- The West Coast breastfeeding rates are outstanding and well above the Ministry of Health targets for 6 weeks, 3 months and 6 months.

**Lactation consultancy:**
- 152 new clients (17 Maori, 4 Other Ethnicity; 75 decile 8-10; 54 rural).

**Peer support**
- Peer support counsellor training programmes in two high decile areas, Granity and Cobden: 17 Mum4Mums trained, 6% were Maori;
- 37 women were referred by lactation consultants to peer support counsellors, plus many referrals from midwives;
- Monthly support and continuing education meetings in Hokitika, Greymouth and Westport;
- Regular Mum4Mum involvement with ante-natal breastfeeding classes.

**West Coast Breastfeeding Rates (Data from Plunket)**



**Breastfeeding education sessions:**

- A widely attended one-day workshop with international educator Carol Bartle, for health professionals and peer counsellors;
- Education sessions for medical centre and social service agency staff;
- Regular education sessions with midwives and ward staff;
- Sessions at 8 ante-natal classes (Westport, Greymouth and Hokitika);
- Presentations to early education centres and playgroups.

**Networking, promotion and advocacy:**

- Active involvement with many agencies and individuals in the health sector and the wider community, including Maori;
- Promotion of World Breastfeeding Week, and Early Childhood expos in Greymouth and Hokitika;
- Advocacy on breastfeeding issues with district councils, CYFS, and other agencies.

## Sources of funding:

- MoH's Healthy Eating Healthy Action breastfeeding support funding;
- PHO's services to improve access and health promotion funding;
- WCDHB's community activity programme funding.

## Expenditure

$78,002

# 6. Cancer Navigation Services

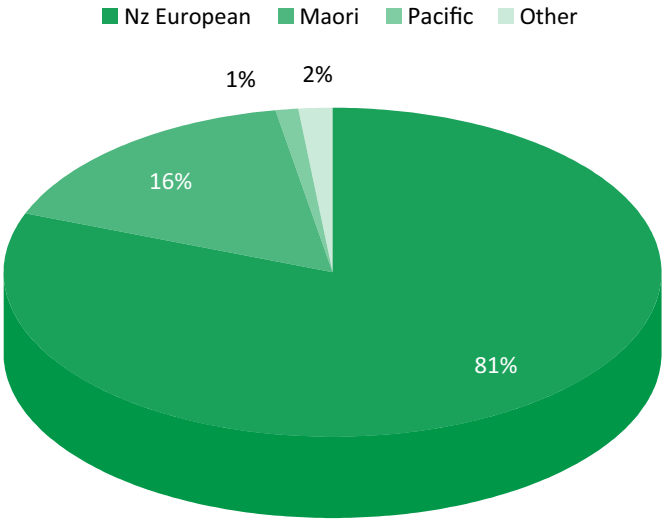
### Aim
To provide community-based lay support and navigation services to people with cancer and their families/whanau, particularly those in rural areas.

### Target group
- People with cancer and their families/whanau.

### Key activities
- Providing information and guidance to clients, family and whanau affected by cancer;
- Facilitation of access to other social support services and financial assistance;
- Face to face sessions with individuals and family/ whanau to develop specific strategies to address their needs;
- An advocacy service for clients with cancer and their family/whanau;
- Community engagement, health promotion and prevention services.

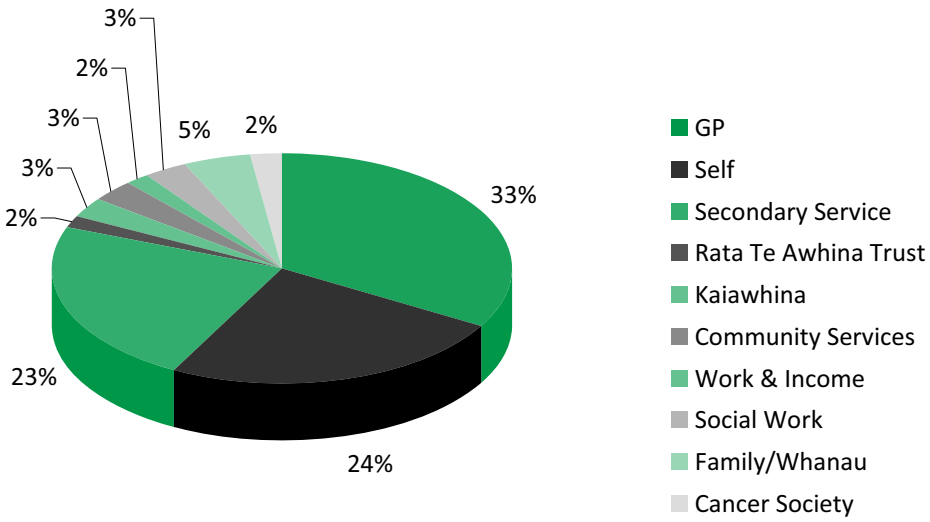
### Progress and Outcomes 2009-2010
- This pilot has come to its conclusion. The evaluation undertaken by Health Outcomes International is due out later in the year. Feedback indicates that the cancer support service is useful in providing tangible supports to patients and their whanau. Some health and social service providers have even noted beneficial flow-on effects for their practice/organisation eg. more efficient use of doctor patient time.
- The West Coast PHO Board has undertaken to support the project for a further year with the Lay Health Navigators being able to assist Long Term Conditions Management patients in Levels 2 and 3 and cancer patients with complex social issues that are affecting their ability to access appropriate health care and social support services.

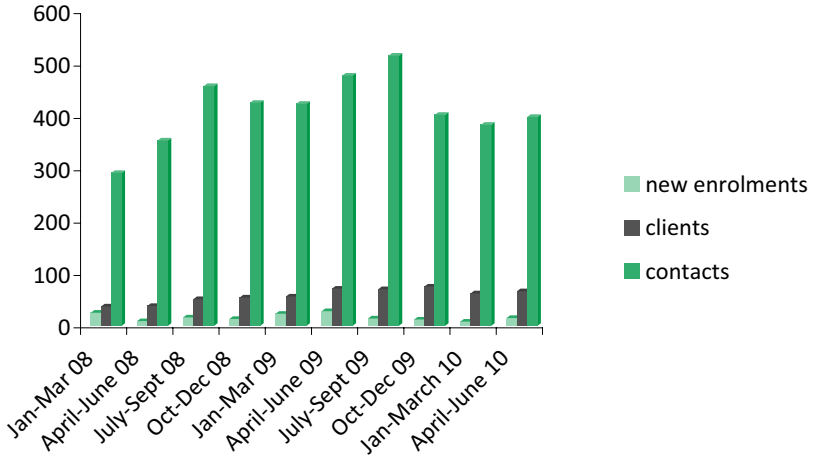
**Cancer Navigation By Ethnicity**





Referral Sources for Cancer Navigation Patients




| | Oct 07-June 08 | July 08 -June 09 | July 09-June 10 |
|---|---|---|---|
| Face to Face contacts | 602 hours | 1149 hours | 996 hours |
| Phone contacts | 66 hours | 119 hours | 94 hours |
| Contacts on behalf | 100 hours | 178 hours | 203 hours |

## Expenditure:

$262,045

# 7. Quality Improvement and Professional Development

## 7.1 PHO Performance Programme (PPP)

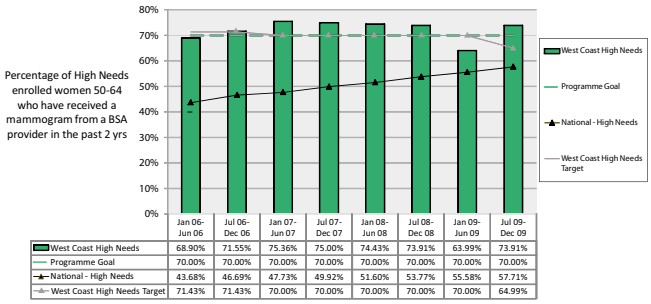
### Aim
To achieve nationally agreed quality indicators.

### Target group
All PHO practices.

### Key activities
- Each practice has an established Quality Improvement Team which manages their programme.
- A Quality Improvement Plan is developed by each practice which guides the practice's efforts for the year. This plan is submitted to the Clinical Governance Committee annually. This process fulfills the RNZCGP's Cornerstone objective E 12.2.
- Financial incentives, based on performance, are paid to practices for use in quality initiatives.
- Data is received from the national programme on the performance of each practice and their providers. This is supplemented by an increasing body of locally collected data.
- Practice visits and group professional development sessions are held regularly.
- Pharmacists are paid to assist cost effective and appropriate prescribing.
- The programme acts as a catalyst to co-ordinate the activities of other programmes: cervical and breast screening; immunisations, both childhood and influenza.

### Outcomes achieved
- For the last full reporting year for which we have data (January to December 2009) the PHO has achieved a total score of 80%.
- Those indicators that relate to the Long Term Conditions programme (diabetes, heart disease and smoking) are reported above in that section of this report.
- Other indicators show steady improvement in the areas of breast cancer screening, cervical cancer screening, childhood immunisations and flu immunisations for those over 65 years.

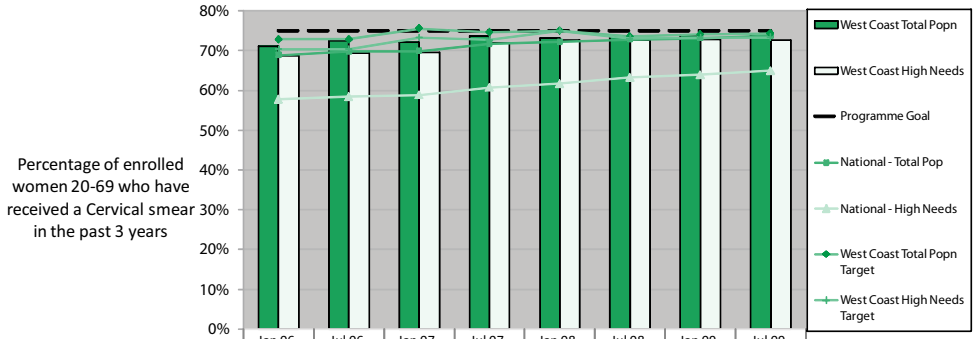
**Trend in Breast Screening Coverage - High Need**




| | Jan 06-Jun 06 | Jul 06-Dec 06 | Jan 07-Jun 07 | Jul 07-Dec 07 | Jan 08-Jun 08 | Jul 08-Dec 08 | Jan 09-Jun 09 | Jul 09-Dec 09 |
|---|---|---|---|---|---|---|---|---|
| West Coast High Needs | 68.90% | 71.55% | 75.36% | 75.00% | 74.43% | 73.91% | 63.99% | 73.91% |
| Programme Goal | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% |
| National - High Needs | 43.68% | 46.69% | 47.73% | 49.92% | 51.60% | 53.77% | 55.58% | 57.71% |
| West Coast High Needs Target | 71.43% | 71.43% | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% | 64.99% |

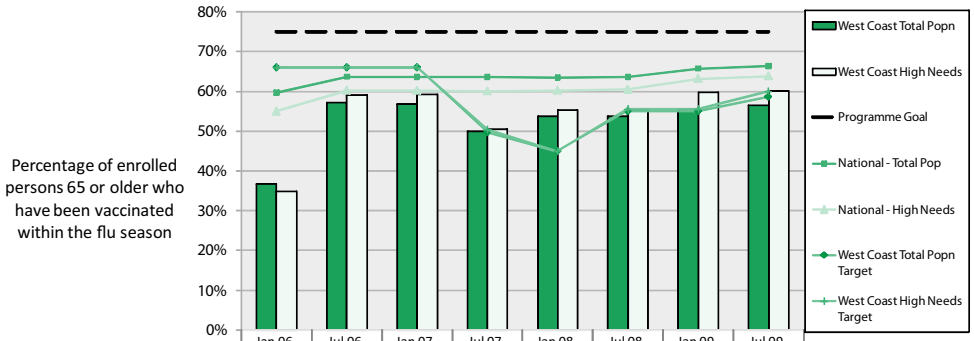
### Expenditure
$217,538

## Trend in Cervical Screening Coverage



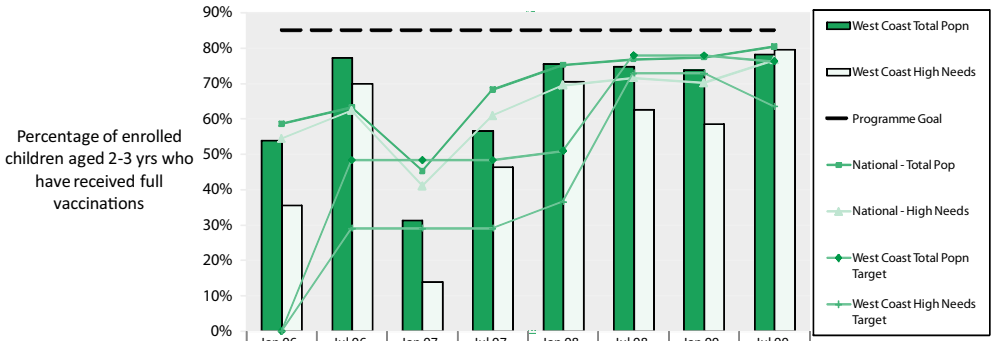

| | Jan 06-Jun 06 | Jul 06-Dec 06 | Jan 07-Jun 07 | Jul 07-Dec 07 | Jan 08-Jun 08 | Jul 08-Dec 08 | Jan 09-Jun 09 | Jul 09-Dec 09 |
|---|---|---|---|---|---|---|---|---|
| West Coast Total Popn | 71.01% | 72.41% | 72.10% | 73.61% | 73.07% | 73.66% | 73.78% | 73.94% |
| West Coast High Needs | 68.73% | 69.28% | 69.45% | 71.92% | 72.57% | 72.70% | 72.84% | 72.55% |
| Programme Goal | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% |
| National - Total Pop | 68.87% | 69.82% | 69.96% | 71.71% | 72.27% | 72.88% | 73.22% | 73.84% |
| National - High Needs | 57.74% | 58.37% | 58.81% | 60.71% | 61.69% | 63.24% | 63.89% | 64.95% |
| West Coast Total Popn Target | 72.84% | 72.84% | 75.57% | 74.60% | 75.00% | 73.57% | 74.07% | 74.28% |
| West Coast High Needs Target | 70.30% | 70.30% | 73.28% | 72.73% | 75.00% | 73.07% | 73.20% | 73.34% |

## Trend in Vaccination Coverage




| | Jan 06-Jun 06 | Jul 06-Dec 06 | Jan 07-Jun 07 | Jul 07-Dec 07 | Jan 08-Jun 08 | Jul 08-Dec 08 | Jan 09-Jun 09 | Jul 09-Dec 09 |
|---|---|---|---|---|---|---|---|---|
| West Coast Total Popn | 36.72% | 57.11% | 56.82% | 49.99% | 53.65% | 53.65% | 55.46% | 56.45% |
| West Coast High Needs | 34.92% | 58.99% | 59.15% | 50.51% | 55.25% | 55.25% | 59.79% | 60.14% |
| Programme Goal | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% | 75.00% |
| National - Total Pop | 59.70% | 63.76% | 63.68% | 63.66% | 63.48% | 63.71% | 65.84% | 66.45% |
| National - High Needs | 55.00% | 60.29% | 60.27% | 60.06% | 60.32% | 60.54% | 63.28% | 63.91% |
| West Coast Total Popn Target | 66.00% | 66.00% | 66.00% | 49.72% | 45.00% | 54.99% | 54.99% | 58.65% |
| West Coast High Needs Target | 66.00% | 66.00% | 66.00% | 50.38% | 45.00% | 55.51% | 55.51% | 60.00% |

## Trend in Childhood Immunisations -2 yr old




| | Jan 06-Jun 06 | Jul 06-Dec 06 | Jan 07-Jun 07 | Jul 07-Dec 07 | Jan 08-Jun 08 | Jul 08-Dec 08 | Jan 09-Jun 09 | Jul 09-Dec 09 |
|---|---|---|---|---|---|---|---|---|
| West Coast Total Popn | 53.85% | 77.18% | 31.36% | 56.52% | 75.42% | 74.71% | 73.75% | 78.28% |
| West Coast High Needs | 35.56% | 69.88% | 13.95% | 46.39% | 70.43% | 62.50% | 58.51% | 79.49% |
| Programme Goal | 85.00% | 85.00% | 85.00% | 85.00% | 85.00% | 85.00% | 85.00% | 85.00% |
| National - Total Pop | 58.60% | 63.26% | 45.32% | 68.18% | 75.24% | 76.80% | 77.35% | 80.38% |
| National - High Needs | 54.39% | 62.28% | 41.08% | 60.86% | 69.47% | 71.59% | 70.08% | 76.51% |
| West Coast Total Popn Target | 0.00% | 48.33% | 48.33% | 48.33% | 51.00% | 77.92% | 77.92% | 76.25% |
| West Coast High Needs Target | 0.00% | 29.12% | 29.12% | 29.12% | 36.62% | 72.93% | 72.93% | 63.51% |

## 7.2 Professional and Practice Development

### Aim
To encourage and support the continuing education and professional development of staff employed by all contracted providers.

### Target group
All members of the general practice teams.

### Key activities
- Professional development activities include local workshops/study days, local video-linked evening education sessions (coverage from Hokitika to Westport), and funded access to conferences and training opportunities mostly outside the West Coast.
- Practice development activities have centered on assisting practices with the RNZCGP Cornerstone practice accreditation programme. Additional practice development activity included a major revision of the Practice Quality Improvement and Professional Development manual, "Excellence in Practice".
- The Professional Development Committee has now formally merged with the Rural Retention Committee to become the Workforce Steering Group, which is both a subcommittee of the Clinical Governance committee and a workgroup of 'Better Sooner More Convenient'.

### Outcomes achieved
**Local study days:**
- Primary Health Day (50 attended)
- Introduction to Contraception workshop (20)
- 2 Diabetes study days (40)
- Smoking Cessation training (13)

**Continuing Medical Education (evening sessions):**
- Dr Anna Dyzel is contracted to co-ordinate the CME programme and arranges the local medical education sessions.
- 10 sessions were presented, with a total of 45 GP attendances, 55 nurse attendances, and 19 'other occupation' attendances. Topics included respiratory medicine, medical records, paediatrics, management of sexual abuse, travel medicine, stroke pathway and TIA guidelines, cervical screening, Hepatitis C, and palliative care.

**Conference/Course leave funded from quarterly allocations to practices:**
- This was at a similar level to 2008-09.

**Cornerstone practice accreditation:**
- 2 practices were accredited this year.
- 2 practices are preparing to accredit by the end of 2010.
- 2 practices are preparing for re-accreditation (having first accredited three years ago).
- All other practices are registered to start the process.

### Expenditure
$76,801

## 7.3 Rural Premium, Reasonable Rostering, and Workforce Retention

### Aim
To assist with sustainability of the workforce through initiatives aimed at supporting retention and recruitment of all primary health professionals in rural communities, including support for after hours care.

### Target group
Service providers contracted to the PHO.

### Key activities
- Reasonable rostering and rural bonus payments to eligible service providers (rural ranking score > 35) contracted to the PHO;
- Two GP registrar scholarships available, to attract young GPs to the Coast;
- Ancillary support to practices (in extraordinary situations) for continuity of medical services;
- Implementation of the after-hours plan;
- Team building and individual mentoring sessions for practice staff, from the PHO primary mental health team;
- 80% of workforce retention funds paid directly to practices for workforce retention issues;
- 100% of reasonable rostering and rural bonus funds paid directly to eligible practices to support their provision of after-hours care.

### Outcomes achieved
- Payments made to eligible contracted practices and providers, as above;
- One GP registrar scholarship issued;
- Further work on the implementation of the after-hours plan with the DHB, including development of generic practice processes for standing orders and facilitation of five one-day training sessions for nurses in common health problems, plus the establishment of HML nurse triage after-hours for all practices;
- Team-building workshop for one practice, and individual mentoring sessions;
- Development of an overarching workforce plan as part of the 'Better, Sooner, More Convenient' Primary Care Plan, with a strong focus on recruitment and retention.

### Expenditure:
$1,129,657

# 8. Subsidary Companies

The PHO took over ownership and operation of Dr Weston's practice, as Dr Weston prepared to retire, in an endeavour to ensure continuity of service for patients of that practice. Considerable efforts were expended seeking to recruit a replacement GP, but to no avail.

*13 Sept 2010*
*It gives me great satisfaction tinged with disappointment to prepare the annual report of the Greymouth Family Health Centre.*

*Since the inception of the Greymouth Family Health Centre (GFHC), the Directors' views were that GFHC could grow to become a profitable and thriving family practice in our town centre. We were able to grow the enrolments from approximately 1,000 when the PHO assumed responsibility for the practice to about 1650 at its peak, and also had very strong enquiries from patients wishing to transfer to our practice. We believe we could have grown the practice considerably more, and had some exciting prospects in the pipeline: health checks for the mines, sexual health clinics, immunizations and the like. The unfortunate problem was that GFHC was not able to recruit a GP through agencies or from other sources. This situation has left us with no option but to find an alternative that would benefit the enrolled population.*

*GFHC directors discussed options with both of the other larger Greymouth practices. The academic practice that was being established at Grey Base Hospital provided an opportunity for continuity of care for patients (and of employment for staff). Staff are to be thanked - they have been very professional through this tough time of uncertainty, keeping the practice open while attempting to recruit a GP.*

*I must give many thanks to my fellow directors, Dave Plumridge and Rob Maskill, for their fantastic input and efforts; also a special thanks to the staff and, especially, the practice manager, Marie, for all their work and professionalism during some uncertain times. Special thanks also to Anthony Cooke for his tremendous support and advice.*

*Many Thanks,*

*Chairman of Directors GFHC*
*Tony Coll"*

Subsequent to year end, the register of patients of Greymouth Family Health Centre has transferred to the Rural Academic General Practice, and former patients of GFHC are now receiving care from that practice (located on the hospital site).

# West Coast Primary Health Organisation Trust

## Directory

### As at 30 June 2010

| | |
|---|---|
| **Principal Business:** | Primary Health Organisation |
| **Address:** | PO Box 544<br>163 Mackay Street<br>Greymouth |
| **Trustees:** | Trustees at 30 June 2010<br>John Boyes<br>Anna Dyzel<br>Maureen Pugh<br>Tim Rochford<br>Rosalie Sampson<br>Tamai Sinclair<br>Richard Wallace<br>Tony Coll<br>Helena Evers |
| **Independent Chairperson:** | John Ayling |
| **Auditors:** | WHK Otago<br>Dunedin |
| **Solicitors:** | Hannan & Seddon<br>Greymouth |
| **Bank:** | Westpac Bank |

# West Coast Primary Health Organisation Trust

## Statement of Financial Performance

For the year ended 30 June 2010

| | Group 2010 $ | Group 2009 $ | Parent 2010 $ | Parent 2009 $ |
|---|---|---|---|---|
| **INCOME** | | | | |
| Revenue | 8,475,532 | 7,837,505 | 8,475,532 | 7,837,505 |
| Interest Received | 43,027 | 57,085 | 55,513 | 57,085 |
| Sundry Income | 201,135 | 49,586 | 100,236 | 49,586 |
| **TOTAL OPERATING INCOME** | 8,719,694 | 7,944,176 | 8,631,281 | 7,944,176 |
| **OPERATING EXPENSES** | | | | |
| Audit Fee | 10,356 | 6,019 | 10,356 | 6,019 |
| Bad Debts | 0 | 204 | - | 204 |
| Bank Fees | 3,070 | 1,734 | 927 | 1,234 |
| Contract Payments | 6,801,364 | 6,263,904 | 7,008,648 | 6,263,904 |
| Insurance | 7,364 | 5,835 | 5,431 | 5,835 |
| Directors Fees | 13,125 | - | - | - |
| Donations | 1,000 | - | 1,000 | - |
| Interest Expense | 5,200 | - | - | - |
| Leases | 153,691 | 104,409 | 124,620 | 104,409 |
| Other Expenses | 373,562 | 279,141 | 269,400 | 278,141 |
| Telecommunications | 38,648 | 29,492 | 32,586 | 29,492 |
| Salaries & Wages | 1,151,788 | 988,047 | 853,903 | 988,047 |
| Trustee Meeting Fees | 69,562 | 64,577 | 69,562 | 64,577 |
| Trustee Reimbursements | 7,451 | 1,941 | 7,451 | 1,941 |
| Depreciation | 89,445 | 53,085 | 63,137 | 52,985 |
| Impairment Adjustment | 41,000 | - | 207,550 | - |
| | 8,766,626 | 7,798,388 | 8,654,571 | 7,796,788 |
| **NET (LOSS) / SURPLUS FOR THE YEAR** | (46,932) | 145,788 | (23,290) | 147,388 |

# West Coast Primary Health Organisation Trust

## Statement of Movements In Equity

For the year ended 30 June 2010

| | Group 2010 $ | Group 2009 $ | Parent 2010 $ | Parent 2009 $ |
|---|---|---|---|---|
| Net (Loss) / Surplus For The Year | (46,932) | 145,788 | (23,290) | 147,388 |
| **TOTAL RECOGNISED REVENUE AND EXPENSES** | (46,932) | 145,788 | (23,290) | 147,388 |
| Equity at Beginning of Year | 862,114 | 716,326 | 863,714 | 716,326 |
| **EQUITY AT THE END OF THE YEAR** | **815,182** | **862,114** | **840,424** | **863,714** |

# Statement of Financial Position

## For the year ended 30 June 2010

| | Note | Group 2010 $ | Group 2009 $ | Parent 2010 $ | Parent 2009 $ |
|---|---|---|---|---|---|
| **EQUITY** | 4 | **815,182** | **862,114** | **840,424** | **863,714** |
| **Represented By:** | | | | | |
| **CURRENT ASSETS** | | | | | |
| Westpac Bank | | 483,125 | 262,272 | 483,125 | 133,987 |
| Westpac Bank Saver | | 1,206,268 | 1,097,669 | 1,206,268 | 1,097,669 |
| Accounts Receivable | | 334,556 | 577,628 | 337,677 | 577,628 |
| Cash on Hand | | 100 | - | - | - |
| Petty Cash | | 179 | 445 | 79 | 445 |
| Loan Greymouth Family Health Centre Ltd | | - | | - | 170,000 |
| Prepayments | | 4,352 | 5,100 | 4,352 | 4,020 |
| **TOTAL CURRENT ASSETS** | | 2,028,580 | 1,943,114 | 2,031,501 | 1,983,749 |
| **NON-CURRENT ASSETS** | | | | | |
| Property, Plant & Equipment | 7 | 300,356 | 207,821 | 204,236 | 204,921 |
| Shares in Greymouth Family Health Centre Ltd | | - | - | - | 5,000 |
| Goodwill | | - | 41,000 | - | - |
| **TOTAL NON-CURRENT ASSETS** | | 300,356 | 248,821 | 204,236 | 209,921 |
| **TOTAL ASSETS** | | **2,328,936** | **2,191,935** | **2,235,737** | **2,193,670** |
| **CURRENT LIABILITIES** | | | | | |
| Westpac Bank | | 96,885 | - | - | - |
| Trade creditors | | 496,729 | 554,051 | 477,432 | 554,051 |
| GST Payable | | 2,986 | 21,621 | 727 | 21,756 |
| Reserved Funding | | 880,549 | 707,285 | 880,549 | 707,285 |
| Employee Entitlements | | 36,605 | 46,864 | 36,605 | 46,864 |
| **TOTAL CURRENT LIABILITIES** | | **1,513,754** | **1,329,821** | **1,395,313** | **1,329,956** |
| **NET ASSETS** | | **815,182** | **862,114** | **840,424** | **863,714** |

For and on behalf of the Trustees

Trustee

Date 1/10/2010

Trustee

Date 1/10/10

WHK FOR IDENTIFICATION PURPOSES ONLY

# Notes to the Financial Statements

## For the year ended 30 June 2010

### 1 STATEMENT OF ACCOUNTING POLICIES

The financial statements presented are for the reporting entity West Coast Primary Health Organisation Trust ("the PHO"). The PHO has been incorporated under the Charitable Trust Act 1957 and is registered with the Charities Commission. The financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand.

The PHO qualifies for Differential Reporting as it is not publicly accountable and is not large as defined by the framework. The PHO has taken advantage of all differential reporting concessions available to it, except for FRS 19 - Accounting for Goods & Services Tax as GST exclusive financial statements have been prepared.

The financial statements have been prepared on the basis of historical cost.

**RECEIVABLES**

Receivables are stated at anticipated realisable value. Bad debts are written off during the period in which they are identified.

**INCOME TAX**

As the PHO is registered with the Charities Commission it is exempt from Income Tax.

**GOODS AND SERVICES TAX**

The financial statements have been prepared so that all components are stated exclusive of GST, except for Accounts Receivable and Accounts Payable, which are required to be shown at their GST inclusive values.

**INVENTORY**

Inventories are stated at the lower of cost and net realisable value.

**GOODWILL**

Goodwill arising on the acquisition of a business represents the excess of purchase consideration over the fair value of the identifiable net assets acquired. Goodwill is amortised to the statement of financial performance on a straight line basis over the period during which benefits are expected to be derived - a period of 5 years.

**REVENUE RECOGNITION**

Revenue from contracts and interest is recognised in the Statement of Financial Performance as earned. Contract income for specific services, which are yet to be delivered, is transferred to the statement of financial position and held as 'Reserved Funding'. When the related service is provided, Reserved Funding is released to the statement of financial performance.

**ASSET IMPAIRMENT**

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

WHK FOR IDENTIFICATION PURPOSES ONLY

# Notes to the Financial Statements

## For the year ended 30 June 2010

**PROPERTY, PLANT & EQUIPMENT**

All owned items of property, plant & equipment are initially recorded at cost and subsequently depreciated as outlined below.

**DEPRECIATION**

Depreciation is charged on a diminishing value basis to allocate the cost of the asset, less any residual value, over its useful life.

The rates used are:

| | |
|---|---|
| Building improvements | 9.5% - 33% DV |
| Motor Vehicles | 30% DV |
| IT, Plant and Furniture | 9.5% - 40% DV |

**BASIS OF CONSOLIDATION**

Subsidiaries are those entities controlled directly or indirectly by the PHO. The financial statements of subsidiaries are included in the consolidated financial statements using the purchase method of consolidation. Intra-entity balances are eliminated in preparing the consolidated financial statements.

The PHO has a 100% interest in Greymouth Family Health Centre Ltd. This company has a 30 June year end and was incorporated on 13 May 2009.

**CHANGES IN ACCOUNTING POLICIES**

There have been no changes in the accounting policies during the year.

**2 RELATED PARTIES**

The following Trustees received payments from the PHO in a capacity other than as a Trustee. All transactions took place on an arms-length, commercial basis.

- Anna Dyzel is a shareholder of Westland Medical Centre, which is a sub-contractor to, and receives funding from, the PHO. Anna Dyzel is also a contractor to the PHO, providing coordination of local continuing education

**3 CAPITAL COMMITMENTS AND CONTINGENT LIABILITIES**

The PHO has contracted to purchase assets valued at nil (2009: NIL) as at balance date.

There were no contingent liabilities at the balance date (2009: NIL).


# Notes to the Financial Statements

For the year ended 30 June 2010

## 4 TRUST EQUITY

| | Group 2010 $ | Group 2009 $ | Parent 2010 $ | Parent 2009 $ |
|---|---|---|---|---|
| **Retained Earnings** | | | | |
| Retained Earnings at Start of Year | 862,114 | 716,326 | 863,714 | 716,326 |
| Net (Loss) / Surplus For The Year | (46,932) | 145,788 | (23,290) | 147,388 |
| Transfer to BSMC Business Case Reserve | (750,000) | - | (750,000) | - |
| Retained Earnings at End of Year | 65,182 | 862,114 | 90,424 | 863,714 |
| **BSMC Business Case Reserve** | | | | |
| Reserve at Start of Year | - | - | - | - |
| Transfer from Retained Earnings | 750,000 | - | 750,000 | - |
| Reserve at End of Year | 750,000 | - | 750,000 | - |
| **TOTAL TRUST EQUITY** | **815,182** | **862,114** | **840,424** | **863,714** |

The PHO has transferred $750,000 in the current year from retained earnings to a BSMC (Better, Sooner, More Convenient) Business Case Reserve.

This reserve is to fund the implementation (over 3 years) of the BSMC business case which has now been approved by the Ministry of Health, as well as by the West Coast DHB.

## 5 NON-CANCELLABLE OPERATING LEASE COMMITMENTS

The PHO has the following non-cancellable operating lease commitments:

| | 2010 | 2009 |
|---|---|---|
| Current Portion | 95,786 | 134,005 |
| Non-Current Portion | 47,601 | 86,447 |
| | 143,387 | 220,452 |

## 6 BANK SECURITY

The PHO has entered into a deed of guarantee with Westpac New Zealand Limited with regard the banking obligations of Greymouth Family Health Centre Limited


# Notes to the Financial Statements

For the year ended 30 June 2010

## 7 PROPERTY, PLANT & EQUIPMENT

**Parent - 2010**

| | Cost | Depn | Accum Depn | 2010 Book Value |
|---|---|---|---|---|
| Building Improvements | 86,563 | 10,833 | 43,100 | 43,463 |
| Motor Vehicles | 39,305 | 8,505 | 19,462 | 19,843 |
| IT & Plant | 232,081 | 43,799 | 91,151 | 140,930 |
| | 357,949 | 63,137 | 153,713 | 204,236 |

**Group - 2010**

| | Cost | Depn | Accum Depn | 2010 Book Value |
|---|---|---|---|---|
| Building Improvements | 159,574 | 15,684 | 47,951 | 111,623 |
| Motor Vehicles | 77,877 | 27,554 | 38,511 | 39,366 |
| IT & Plant | 243,024 | 46,207 | 93,659 | 149,367 |
| | 480,475 | 89,445 | 180,121 | 300,356 |

**Parent - 2009**

| | Cost | Depn | Accum Depn | 2009 Book Value |
|---|---|---|---|---|
| Building Improvements | 86,563 | 15,436 | 32,267 | 54,296 |
| Motor Vehicles | 39,305 | 6,237 | 10,957 | 28,348 |
| IT & Plant | 169,629 | 31,312 | 47,352 | 122,277 |
| | 295,497 | 52,985 | 90,576 | 204,921 |

**Consolidated - 2009**

| | Cost | Depn | Accum Depn | 2009 Book Value |
|---|---|---|---|---|
| Building Improvements | 86,563 | 15,436 | 32,267 | 54,296 |
| Motor Vehicles | 39,305 | 6,237 | 10,957 | 28,348 |
| IT & Plant | 172,629 | 31,412 | 47,452 | 125,177 |
| | 298,497 | 53,085 | 90,676 | 207,821 |

## 8 EVENTS SUBSEQUENT TO BALANCE DATE

Subsequent to balance date the directors of the Trust's subsidiary company, Greymouth Family Health Centre Limited, have made the decision to liquidate the company.


WHK

# Audit Report

## To the Trustees of the West Coast Primary Health Organisation Trust

We have audited the financial statements on pages 2 to 8*. The financial statements provide information about the past financial performance and financial position of the Trust and Group as at 30 June 2010. This information is stated in accordance with the accounting policies set out on pages 5 and 6.

### Trustees Responsibilities

The Trustees are responsible for the preparation of financial statements which fairly reflect the financial position of the Trust and Group as at 30 June 2010 and the results of their operations for the year ended on that date.

### Auditors' Responsibilities

It is our responsibility to express an independent opinion on the financial statements presented by the Trustees and report our opinion to you.

### Basis of Opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- the significant estimates and judgements made by the Trustees in the preparation of the financial statements;
- whether the accounting policies are appropriate to the Trust's and Group's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with New Zealand Auditing Standards. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to obtain reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Other than in our capacity as auditors we have no relationship with or interests in the Trust or its subsidiary.

### Unqualified Opinion

In our opinion the financial statements on pages 2 to 8* fairly reflect the financial position of the Trust and Group as at 30 June 2010 and the results of their operations for the year ended on that date.

Our audit was completed on 1 October 2010 and our unqualified opinion is expressed as at that date.

WHK Otago
Dunedin

* These pages appear on pages 29 to 35 in this document.