West Coast
Te Tai o Poutini
Primary Health

Annual Report 2010-2011

Contents

1. Trustees Report

Trustees take pleasure in presenting the Annual Report and Financial Statements for the year ended 30th June 2011.

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.

The PHO is funded for a range of primary health care services to residents enrolled with a West Coast medical centre. These services 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 for the maintenance of good health.

Trustees represent 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.

Besides our relationship with practices and various partners in our programme our principal relationship continues to be with the West Coast District Health Board (WCDHB). Last year's Annual Report noted that 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 Coast, by integration of a number of services: general practice, community nursing, needs assessments services and allied health. Implementation is now underway, albeit a little behind schedule on account of the time it has taken to establish and focus the various service improvement teams.

The West Coast PHO's Clinical Governance Committee is 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 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 Clinical Governance Committee and, in particular, its Chair, Dr Greville Wood.

During the year we said goodbye to the PHO's then Clinical Advisor Dr Jocelyn Tracey. Dr Tracey made an energetic and much respected contribution to the work of the PHO and its various programmes.

The West Coast PHO concluded the year with a deficit of $222,688 which has been funded from reserves.

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 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.

The attendance of Trustees at Board meetings is as follows:

John Ayling (Chair)	6	
Helena Evers	3	Resigned 05/04/2011
Tony Coll	5	
John Boyes	6	
Maureen Pugh	5	
Anna Dyzel	6	
Rosalie Sampson	6	
Tamai Sinclair	3	Term completed 20/03/2011
Tim Rochford	2	
Richard Wallace	2	
Francois Tumahai	2	Term started 28/04/2011
Toni Caldwell	2	Appointed 28/04/2011

The PHO continues to be well served by *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 as attested by the results that appear in this report.

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 PHO Board of Trustees.

John Ayling
Chair

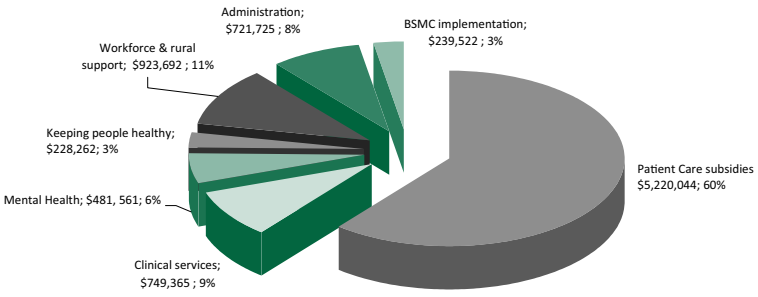
2. Management Report

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

- it provides funds to, and otherwise supports, the provision of primary health care, primarily through the region's medical centres (or general practices), and
- 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 2010-11



On average, the PHO had 30,910 patients enrolled via the medical centres up and down the West Coast, compared with 30,456 the previous year, and compared with a Statistics Department resident population provisional estimate of 32,700 as at 30th June 2010. This average level of enrolment represents 94.5% of the estimated resident population as at 30th June 2010.

All general practices on the West Coast, from Karamea to the Haast, are contracted to the PHO and all practices remain Very Low Cost Access (VLCA) practices, which means on-going lower medical and pharmaceutical costs to the community ($17 per adult cf $35-50 in those parts of the country not signed up to VLCA).

The following table shows the patient co-payment for a standard visit to a medical centre within normal office hours during the 2010-11 financial year:

The PHO's long term conditions programme continues to successfully enrol people in need of additional, planned, proactive support to better manage their condition.

Under six	$ 0.00
6 to 17 yrs	$ 11.50
Adults	$ 17.00

The PHO subsidised 130,923 visits by enrolled patients to its contracted medical centres during the year. This was up 7% from 122,254 visits during the previous twelve months and 119,933 visits during the twelve months prior to that.

This represents an average of 4.2 visits during the year for each enrolled patient in the PHO. The average subsidy for each enrolled patient was therefore $186.43 (incl. GST) during the year. The average subsidy per patient visit was $44.02 (incl. GST).

Last year the PHO responded to an opportunity to submit to the Ministry of Health (MoH) an Expression of Interest in providing 'better, sooner, more convenient primary health care'. This in turn led to the writing of a detailed plan (or business case) to improve the long-standing and seemingly intractable problems within primary care on the West Coast, namely:

- shortage of permanent GPs and difficulty recruiting and retaining;
- continuing financial losses (principally in publicly owned practices);
- patients waiting too long for routine appointments.

The proposed solutions were signed off by the DHB and the MoH. An 'alliance agreement' was the stipulated contractual device for implementing the solutions as outlined in the 'business case'. An alliance leadership team is in place and plans are being drawn up for an Integrated Family Health Centre (IFHC) in Westport. There is increasingly close cooperation between West Coast and Canterbury DHBs. The three core problems that prompted the development of the business case still persist.

In term of its own operations, the PHO's long term conditions programme continues to successfully enrol people in need of additional, planned, proactive support to better manage their condition. And the supporting Green Prescription exercise programme continues to help more West Coasters become physically active.

Finally, I'd like to record my 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

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 2010-2011

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.

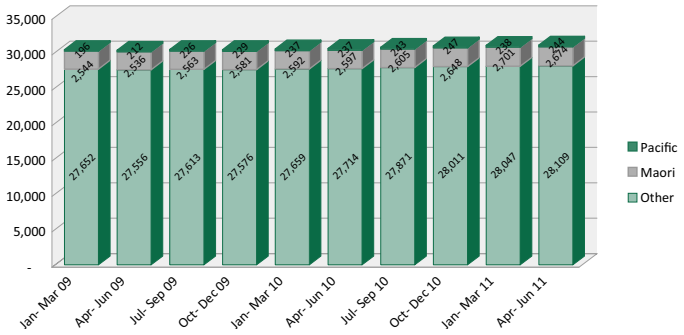
Cost of co-payment during 2010-11

Under 6 yrs	$0
6 to 17 yrs	$11.50
Adult	$17.00

Outcomes measured

On average, the PHO had 30,910 patients enrolled during the financial year. The number of enrolled patients increased slightly from 30,719 during the first quarter (Jul-Sep 10) to 31,027 during the last quarter (Apr-Jun 11).

Enrolments over time by ethnicity



The PHO subsidised 130,923 visits by enrolled patients to its contracted medical centres during the year. This was up from 122,254 visits during the previous twelve months (a 7% increase), and from 119,933 the year before that.

This represents an average of 4.2 visits for each enrolled patient in the PHO. The average subsidy for each enrolled patient was therefore $186.43 (incl. GST) during the year. The average subsidy per patient visit was $44.02 (incl. GST).

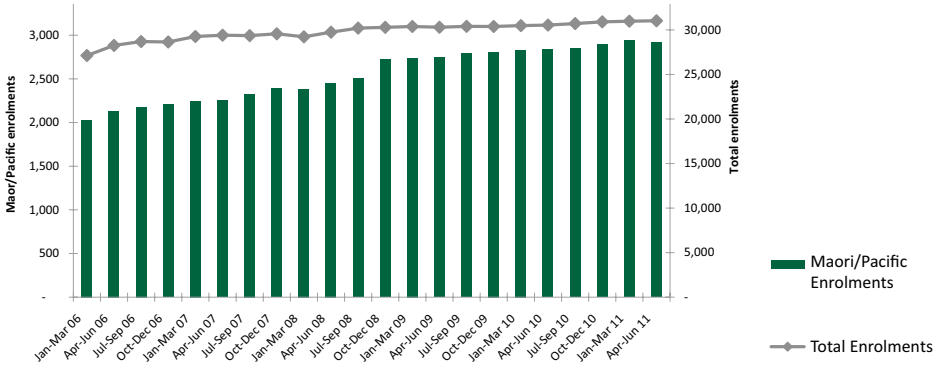
Expenditure

$5,038,329 (cf. $4,790,258 and $4,506,811 in each of the two previous years).

3.1 Access for Maori

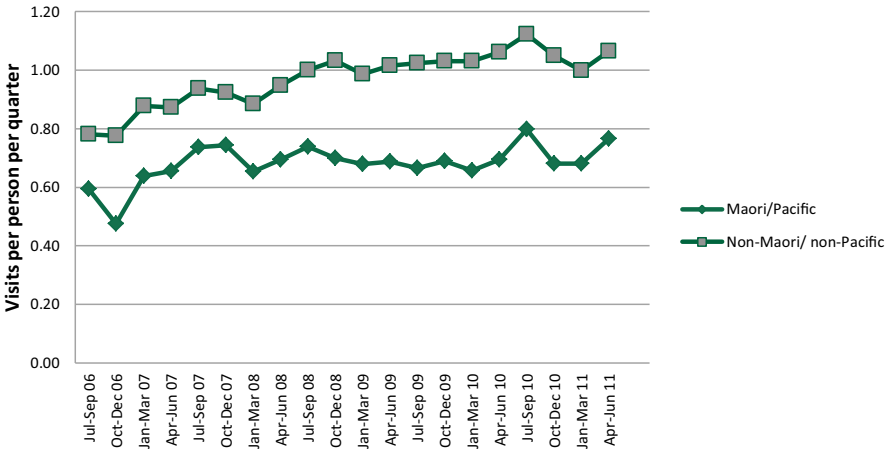
Over the past 22 quarters, enrolments in the PHO by Maori and Pacific Island people have grown 44%, while those by people of all other ethnicities have grown 14%.

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 per quarter



Why the PHO does what it does

The Western world faces an epidemic of long term conditions, including diseases such as diabetes and cardiovascular disease. To our communities the inexorable increase in these diseases may seem out of control and inexplicable.

To those of us who work in the health arena, however, while the rising epidemic of chronic disease might be uncontrolled, it is entirely explicable. It is the result of living in the hostile obeso-genic environment that is modern, sedentary, Western, civilised life.

Chronic conditions arise in the Western world because of too high energy intake (diets containing too much fat, salt and sugar) combined with too low energy outputs (sedentary lifestyles, cars instead of walking, remote controls, jobs sitting at desks and computers).

The PHO is committed to working with our communities to communicate how individuals, families, communities, our society and our nation can comprehend and respond to this chronic conditions challenge we face.

Our strategy has four elements to it:

1. promoting healthy lifestyles (more fresh fruit and vegetables, more physical activity, less fat, salt and sugar, stop smoking) to the entire community (see section 4);

2. screening certain groups within our community we know are in danger of developing chronic conditions - basically this is every woman over 55, every man over 45, and for Maori it's ten years younger than that - every Maori woman over 45 and every Maori man over 35 (see section 5.1);

3. working with those identified through that screening process as being at high risk (defined as >15% likelihood) of a heart attack or stroke within the next five years to reduce their level of risk (see section 5.2);

4. working with those identified as actually having one of the chronic diseases (diabetes, cardiovascular disease, chronic obstructive pulmonary disease etc) to support them to live well with their conditions, and reduce complications (see 5.3 – 5.5).

4. Keeping People Healthy

Expenditure

The PHO spent $270,366 on the various 'Keeping People Healthy' programmes.

4.1 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 groups

West Coasters who are inactive or at risk of developing diabetes and/or cardiovascular disease:

- 18 years of age or over – Adult Programme;
- 13 to 18 years – Active Living Youth Programme, as identified by general practices.

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.
- 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 8-10 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, swimming pool facilities, gyms, bowling club, etc.
- Active Living Youth Programme for youth 13 to 18 years of age, focusing on improved nutrition and increased levels of physical activity, targeting at-risk and overweight/obese youth.

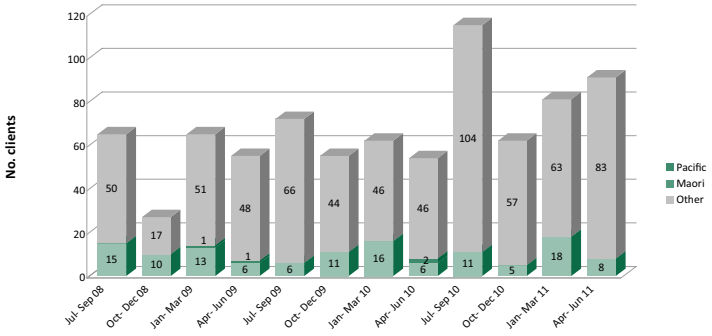
Progress 2010-2011

- Green Prescription in Westport is well established since commencing in September 2010, exceeding the expected referrals for the year;
- Active Youth programme progressing well since commencement in April 2010, numbers are relatively small but the benefits to this group of at-risk youth are enormous;
- Green Prescription Grey/Westland referrals also exceeded the targets expected for the year.

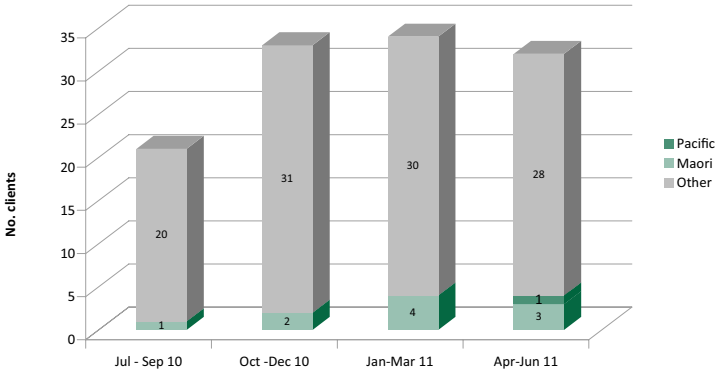
Outcomes achieved

- 349 referrals were received in the 2010/11 year for Grey/Westland; 12% were for Maori, exceeding the 10% target.

Green Prescription Clients - Grey/Westland

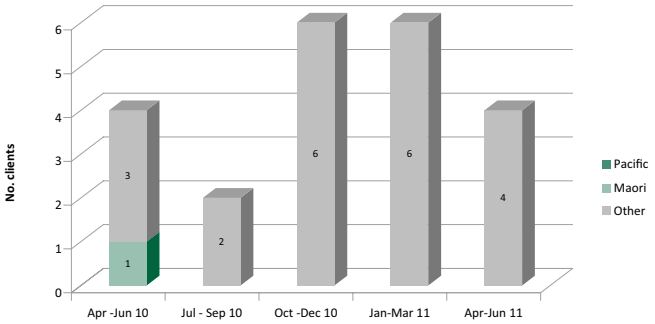


Green Prescription Clients - Buller



- 120 referrals were received in the 2010/11 year for Buller, 8% were for Maori.
- The following graph shows the number of Green Prescription youth enrolled since the programme began:

Active Living - Youth Programme



4.2 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

- peer counsellor (Mum4Mums) training and support;
- lactation consultancy;
- breastfeeding education sessions;
- networking and collaboration with the DHB, primary health sector and community;
- promotional activities and advocacy.

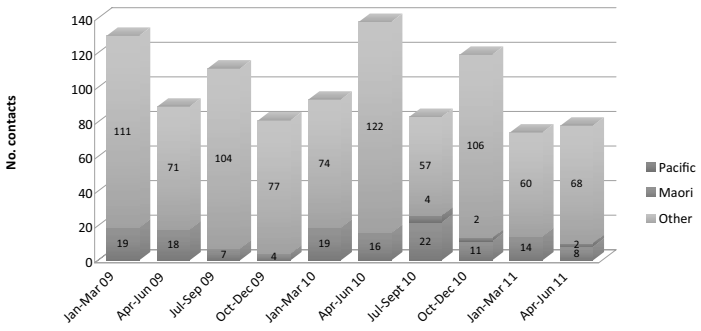
Progress and outcomes 2010-11

- The West Coast breastfeeding rates are far exceeding the national targets at 6 weeks: 81% for Maori and 72% overall compared to the national target of 74%, and at 6 months, 32% for Maori and 39% overall compared to the national target of 27%.

Lactation consultancy:

- 116 new clients (67 decile 8-10; 49 rural);
- Of the 354 contacts this year, 16% were with Maori mums.

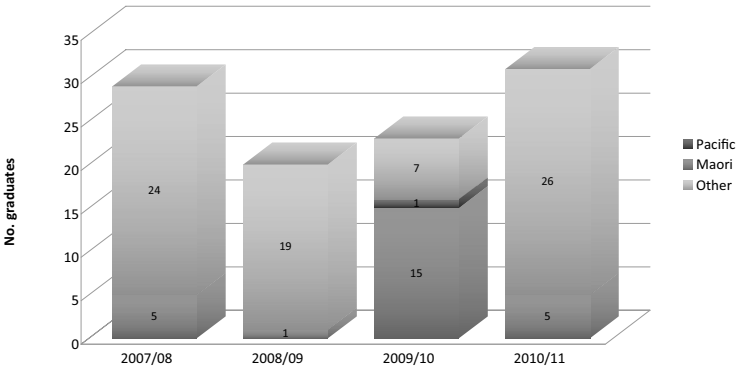
Lactation Consultancy Contacts



Peer support:

- 26 women were referred by lactation consultants to peer support counsellors, plus many referrals from midwives;
- regular support and continuing education meetings in Hokitika, Greymouth, Franz Josef, Reefton, Westport and Granity;
- regular Mum4Mum involvement with ante-natal breastfeeding classes;
- peer support counsellor training programmes in Franz Josef, Hokitika, Granity and Cobden with 31 graduate Mum4Mums trained, 16% were Maori.

Mum4Mum Graduates



Breastfeeding education sessions:

- breastfeeding sessions held at ante-natal classes (Westport 4, Fox Glacier 1, Franz Josef 1, Hokitika 1, Greymouth 4);
- education sessions held for medical centre and social service agency staff;
- regular education sessions with midwives and ward staff.

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 within the community and practices across the West Coast.

4.3 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

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

Key activities and outcomes 2010-2011

Men's Health Awareness:

- 2 forum style presentations with guest speakers were held at Marist Rugby Club Greymouth (35 men attended)and Westland Milk Products Hokitika (50 men attended).
- Two men's wellness clinics were held at Westland Medical Centre and Rural Academic General Practice where men were invited to come and have their cardiovascular risk assessments done. 19 Maori men attended the Rural Academic General Practice clinic and 14 men the Hokitika clinic. 50 men attended the Pike River Mine 'eating well for shift workers' presentations.

Smokefree May:

- all practices and pharmacies across the West Coast participated with large promotional displays throughout May.
- the launch of the new preventing smoking during pregnancy banners in workplaces, practices and pharmacies.

Diabetes Awareness week:

- this week was promoted throughout the practices and pharmacies with the 'sweet as' theme. Promotion of the 'staying well with type 2 diabetes' courses in newspapers across the West Coast and on the PHO website.

Heart Week:

- An extensive campaign was undertaken to try and increase the uptake of West Coasters having their 5 year cardiovascular risk assessment done. 'Are you at risk of heart attack or stroke' was the theme for promotional displays in practices, pharmacies and businesses in all districts with radio and newspaper advertising.

Influenza Vaccination Promotion:

- 'Rusty' the PHO health promotion dog promoted the influenza vaccine at the supermarket tours in Westport, Greymouth and Hokitika, with 380 people contacted during these visits. The majority of practices held dedicated 'flu' clinics beginning in March and two community clinics were held in Greymouth at a local church with 46 free flu vaccines given to eligible people.

Bowel Cancer Awareness Poster Campaign:

- This innovative and eye catching promotion saw over 800 bowel screening promotional posters strategically placed in toilets of participating businesses, practices, pharmacies, the DHB and NGOs across the entire West Coast. The underlying message was: 'don't ignore your symptoms'.

Other community collaborative health promotion initiatives:

- included 'children's day' Hokitika, Daffodil Day, 'walk to work day', world breastfeeding week, cervical screening month and 'bikewise month'.

Healthy Lifestyle Ambassador Awards:

- were presented to individuals in Westland, Grey and Buller districts.

5. Clinical Programmes and Services

5.1 Screening for Cardiovascular Disease and Diabetes

Aim

To identify individuals at high risk of a cardiovascular event (heart attack, stroke or angina) or diabetes, with a view to providing appropriate patient management and support 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 prediabetes.
- To increase physical activity; 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 risk.

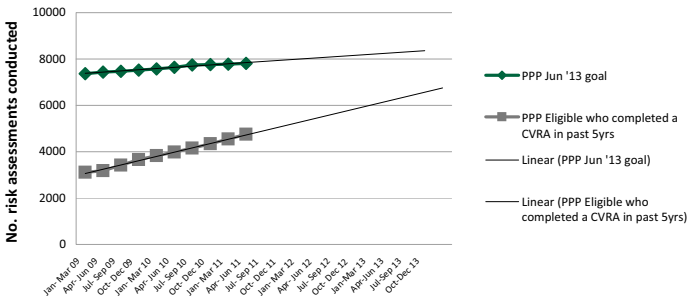
Progress 2010-2011

- Practice nurses and General Practitioners are routinely providing cardiovascular risk screening with emphasis on high needs groups, including Maori and Pacific.
- All identified current smokers are given brief advice to stop smoking, with many referred to smoking cessation services.

Outcomes achieved

- 1,546 screens were completed in the 2010/11 year. Risk assessments include all initial screens, immediate follow-ups for identified high risk individuals, and annual risk assessment reviews.
- 60% of the 2,013 target of eligible population have now been screened.

Progress towards risk assessing the indicated WC population (cumulative since inception of programme)



- During the year 6% of all risk assessments completed were for Maori.
- 81% of those screened were not smoking.
- The condition most commonly identified during the cardiovascular risk assessment process was metabolic syndrome.

Expenditure

$23,083

5.2 Treatment for those identified with High Cardiovascular Risk

Aim

To reduce the 5-year cardiovascular risk to less than 15% for those identified individuals.

Target group

Individuals identified as having greater than 15% risk of developing cardiovascular disease.

Key activities

- 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 identified with high risk have an annual assessment of their risk level.
- All identified smokers are given brief advice and support to quit;
- Lifestyle interventions are recommended: diet, physical activity, and advice on weight management; and referrals made to relevant primary care providers;
- optimal pharmacological treatment is commenced;
- regular follow-up monitoring of cardiovascular risk.

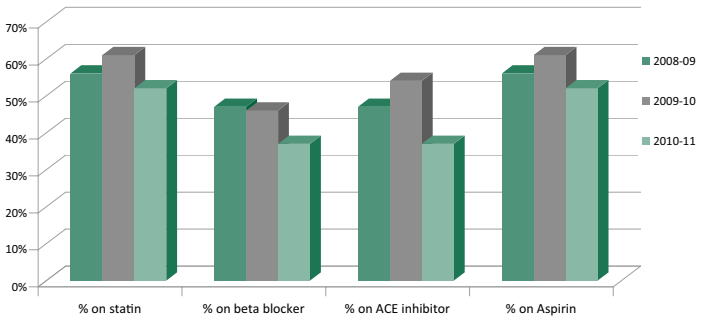
Progress 2010-2011

- Of the 1,546 screens conducted (see previous section), 361 individuals (23%) were identified as having 15% or greater risk of a CV event.
- Planning for a study day for clinicians regarding the clinical management of people with identified cardiovascular risk 15% or greater.
- Many people with high risk are referred to Green Prescription to help them become more active.

Outcomes achieved

- The following graph shows the % of high risk patients followed up for one year who are on a preventative medication:

Percentage High Risk Patients (> 15%) on Relevant Medications



5.3 Long Term Conditions (LTC) programme

Aim

To improve health outcomes, and self-management, 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

- The Long Term Conditions (LTC) programme is now well established within all of the general practice teams on the West Coast and is part of the process of 'planned care' 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 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 or community support programmes as required.

Progress 2010-2011

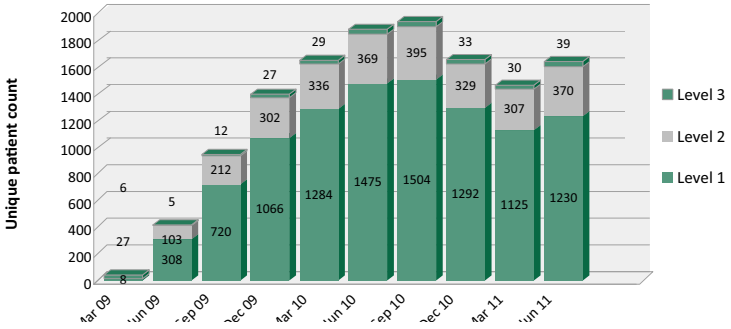
- Establishment and integration of the Health Navigator service into practices to support the LTC programme, with the aim of supporting patients with complex social issues that are affecting their ability to access health care and social support services.
- Integration of a PHO Kaiawhina into practices to support the LTC programme in the Grey district.
- Upgrade of information technology utilised to support the programme.

Outcomes achieved

- Enrolments have been increasing. In total, 1639 enrolments have been made into the LTC programme to date: level one, 1230; level two, 370; level three, 39.
- Maori make up approximately 5% of the 45 years + age range (the age group predominantly enrolled in the LTC programme), compared with 6% Maori enrolled in the LTC for the 2010/11 period. Other ethnicities make up approximately 95% of the 45 years + age range, compared to 94% enrolled in the LTC for the 2010/11 period.

The following graph shows the number of individuals enrolled since the programme began:

Enrolments in the Long Term Conditions Programme



Source of funding

Services provided as part of the LTC programmes are funded by Care Plus, Diabetes Annual Review and Services to Improve Access funding streams.

Expenditure

$185,600

5.3.1 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 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.

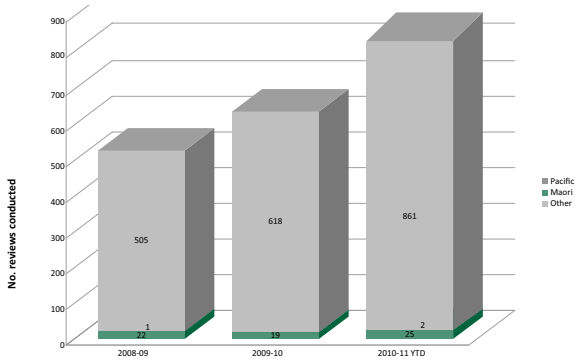
Progress 2010-2011

- CVD annual reviews are a routine aspect of planned care as part of the Long Term Conditions programme. Patients are receiving individualised care based upon their clinical needs as well as their ability to self-manage their condition.
- Close linkages have been established with the Cardiac Nurse Specialists to further support people with CVD.
- All identified smokers are offered brief advice and support to quit.

Outcomes achieved

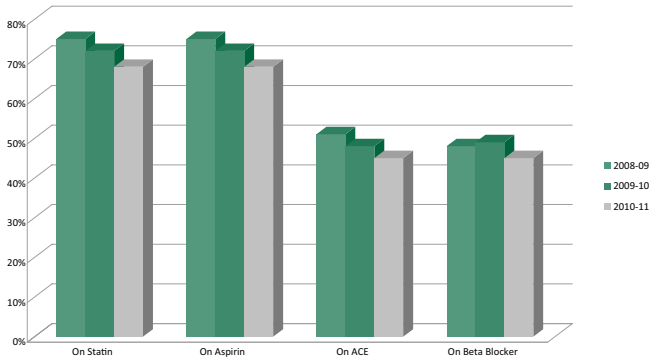
- 900 reviews were completed in the 2010/11 year compared to 637 for the 2009/10 year. According to the PHO Performance Programme (PPP) the estimated number of the people with cardiovascular disease for the total population is 935.

CVD Annual Reviews



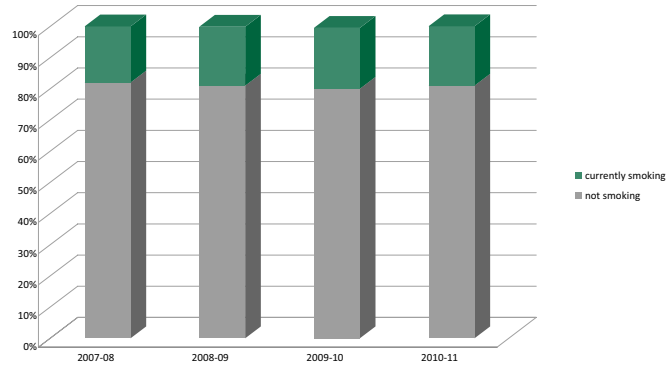
- Myocardial infarction and angina made up 66% of all conditions identified as part of the clinical history of those having a cardiovascular annual review.
- The following graph shows the percentage of people reviewed, on preventative medication over the last three years:

Percentage CVD patients on relevant medications



- The following graph shows the percentages of people reviewed who are smokers and nonsmokers. Of those reviewed 81% were not smoking:

Percentage CVD patients who are non-smokers



Expenditure

Included in $185,600 of LTC expenditure

5.3.2 Diabetes Annual Reviews

Aim

To improve health outcomes, self-management and quality of life for all people with diabetes.

Target group

All patients with diabetes.

Key activities

- to provide an annual review for people 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.

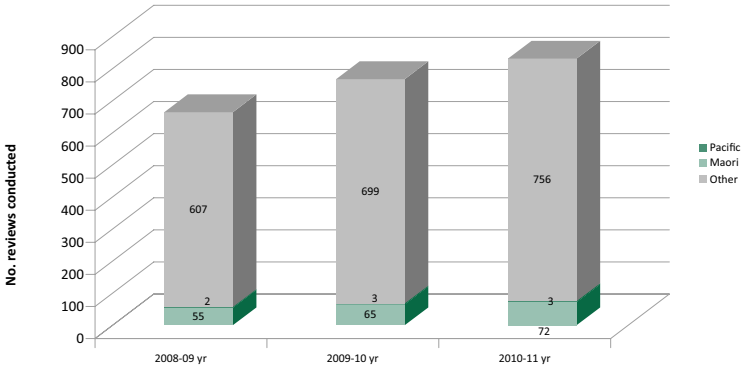
Progress 2010-2011

- Diabetes annual reviews are a routine aspect of planned care as part of the Long Term Conditions programme.
- Retinal screening clinics are held every quarter in the main centres and peripheral clinics in the more rural areas as needed.
- Practices receive quarterly reports on annual review activity.
- All identified smokers are offered brief advice and support to quit.
- A Type 2 Diabetes Education workshop was held, with 15 nurses attending.

Outcomes achieved

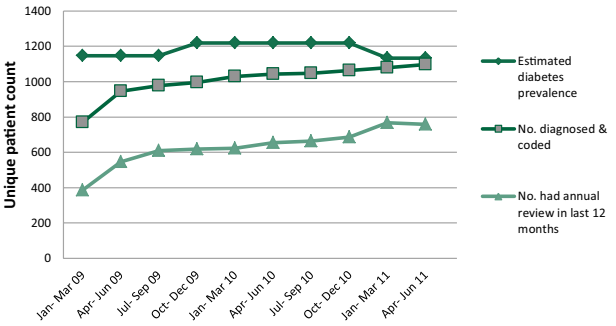
- The target of up-to-date retinal screening for 85% of patients was nearly met, with 81% of patients being screened within the last two years.
- 11% of patients having their diabetic review were identified as current smokers.
- 831 annual diabetes reviews were completed this year (9% of which were for Maori).
- 831 reviews represents 66% of those who have been diagnosed with diabetes (cf. target of 65%).

Diabetes Annual Reviews



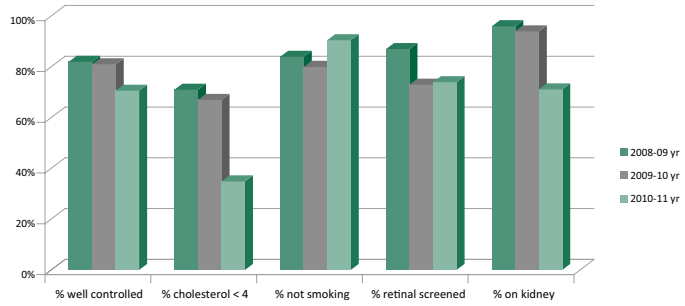
The following graph shows the number of annual reviews completed; the number of people diagnosed as having diabetes; and the estimated diabetes prevalence, over the last 2 and a half years:

Diabetes prevalence, detection & clinical review



This final graph compares the clinical outcomes for reviews over the last three years (it should be noted that the comparison of % cholesterol <4 began January 1st 2010; prior to this the measurements were % cholesterol <5:

Clinical Outcomes from 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 course aims to enable people with diabetes to self-manage their condition.

The diabetes self-management course underwent some changes over the last year and is now called 'Living Well with Type 2 Diabetes'. The course is provided by the PHO over a four week period. This course is still designed to improve individual (and family/whanau) knowledge, self-care skills and self-confidence whilst living with Type 2 diabetes. Courses were held in Greymouth (2), and Westport (1), with a total of 13 people attending overall. Plans are underway to modify how these courses can be run due to the low attendance rates over the past year.

Expenditure

Diabetes Annual Reviews included in $185,600 of LTC expenditure. An additional $56,380 was spent on retinal screening.

5.3.3 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 or provided by primary health care, secondary health care or in the wider community.

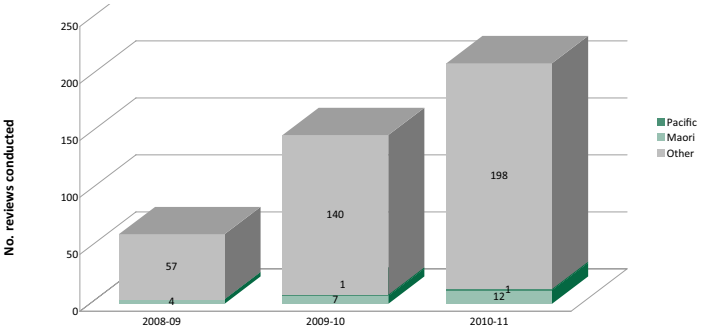
Progress 2010-2011

- COPD annual reviews are a routine aspect of planned care as part of the Long Term Conditions programme.
- Practices receive quarterly reports on annual review activity;
- All identified smokers are offered brief advice and support to quit.

Outcomes achieved

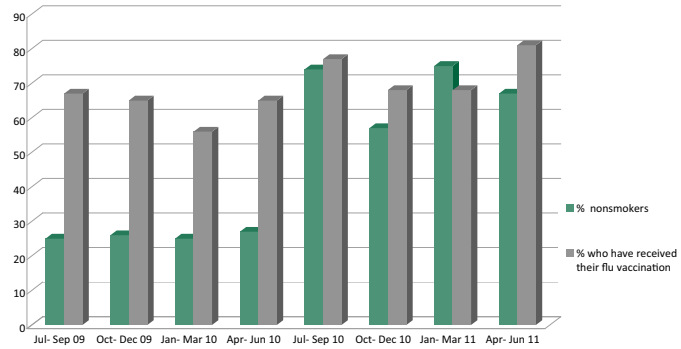
- 211 annual reviews were completed in the 2010-2011 year. The expected prevalence for Maori (according to 2006/07 New Zealand Health Survey data) with COPD is 88 and for Other ethnicity 870 on the West Coast.
- of those reviewed, 75% had a flu vaccination recall made, and 83% have been given a COPD management plan.
- 5% screened were Maori compared with expected prevalence of 9%, and 95% Other ethnicities compared with expected prevalence of 91%.
- The following graph shows the enrolments by ethnicity since the programme began in March 2009:

COPD Annual Reviews

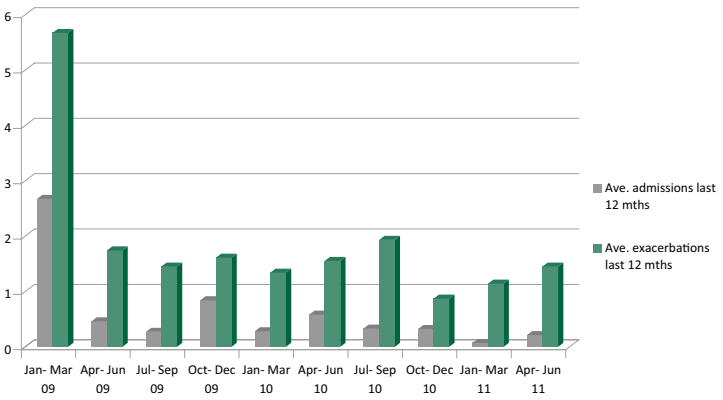


- The following graph shows the number of people not smoking and who have had their flu vaccination recall at the time of their annual review:

Outcomes for those who'd had a COPD Annual Review



- The average COPD admission rate per patient was 0.22 per year compared with 0.49 last year.
- The average COPD exacerbation was 1.3 per patient this year compared with 1.4 last year.
- The following graph shows the admission rates and exacerbations by quarter:



Expenditure

Included in $185,600 of LTC expenditure

5.4 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, in particular high needs groups.

Key activities

- Coast Quit smoking cessation programme is well established and is provided by trained nurses, GPs, rural nurse specialists, pharmacists and pharmacy staff across the West Coast.
- All practices are working towards the Ministry of Health Tobacco Health Target of "90 percent of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2012".
- Recording of a patient's smoking status is routine at all practices and rural clinics.

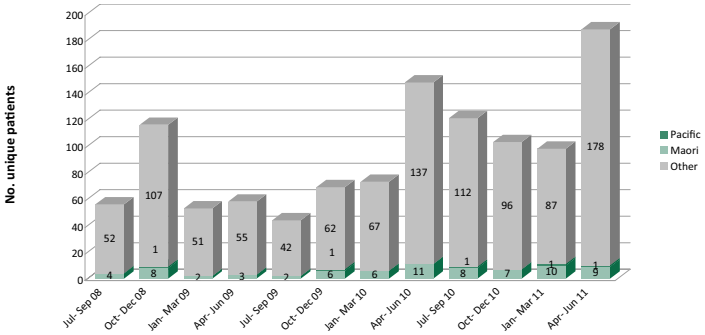
Progress 2010-2011

- This year has seen a record number of enrolments to the PHO smoking cessation programme. 250 places were available on Coast Quit for the 2010-2011 year, enrolments were double this.
- All PHO programmes are linked into this smoking cessation programme, so anyone identified as smoking and ready to quit can be offered this service or another alternative of their choice.
- Two Motivational Interviewing training days were held this year with, 35 attendees.
- Two Coast Quit smoking cessation and one advanced training day were held this year, with 40 attendees.

Outcomes achieved

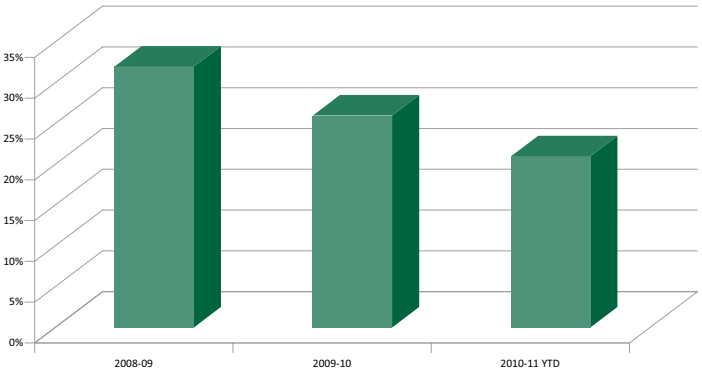
- 65% of the eligible West Coast population have had their smoking status recorded;
- 510 enrolments in the programme: 89% enrolled with a practice or rural clinic, 11% with a local pharmacy;
- Of the 510 enrolments, 7% were Maori.

Smoking Cessation Clients



- The following graph shows the quit rates after three months of enrolling in the Coast Quit programme:

% stopped smoking at 6 month followup



- As more people attempt to stop smoking, the rate of successful quitting has declined. However, a quit rate of 1 in 5 is regarded as acceptable. It is also well known that individuals may make several attempts at quitting before they succeed.

Funding

Revenue received for smoking cessation was $20,000. Expenditure was $42,719 to meet demand. The PHO contributed the additional $22,719 from its reserved funds.

5.5 Health Navigator Service

Aim

To assist high needs patients with LTCs, including cancer, to access timely and appropriate social and health services.

Target group

Long Term Conditions (LTC) Management patients in Level 2 and 3 and cancer patients with complex social issues that are affecting their ability to access health care and social support services.

This will include patients with cancer, diabetes, COPD, CVD in the first instance.

Key activities

- to provide additional support for LTC patients and their whanau with complex social needs;
- to improve access to health care for these patients;
- to support the medical centres in caring for these patients;
- to improve access to social support services for these patients;
- to improve health outcomes;
- to enhance their health literacy and ability to self-care;
- to decrease unplanned ED visits and hospital admissions.

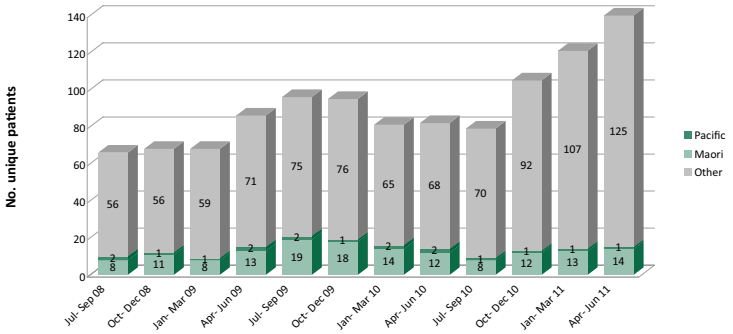
Progress 2010-2011

- On the completion of the 3 year Cancer Navigator pilot project in June 2010 which was funded by the Ministry of Health, the scope of the Navigators broadened to include LTC. The Navigators have targeted their support to those enrolled Level 3 patients and those Level 2 patients where navigation would be of greater benefit to health outcomes, including those with cancer.
- An evaluation of the revised service has taken place and its findings support the continuation of this service.

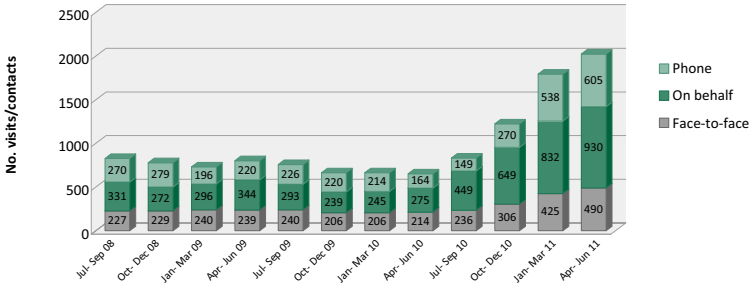
Outcome achieved

The graphs below illustrate the growth in the service since the 1 July 2010 revamp of the programme to include LTCs:

Health Navigator Patients



Health Navigator Visits/Contacts By Type



5.6 Health Checks for Clients of the Corrections Department

Aim

To provide free acute care and general check-ups for high needs 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 prescriptions.

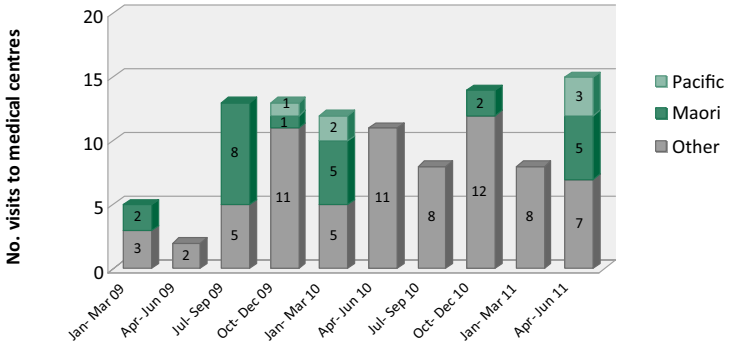
Progress 2010-2011

- Utilisation of this programme was very similar to last year.
- This programme continues to benefit a very small number of high needs individuals.

Outcomes achieved

- 16% were for Maori and 7% Pacific;
- 45 contacts were made at medical centres this year, as shown in the graph below:

Corrections Department Clients



Expenditure

$1,588

5.7 Contraception and 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 and sexual health services (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.

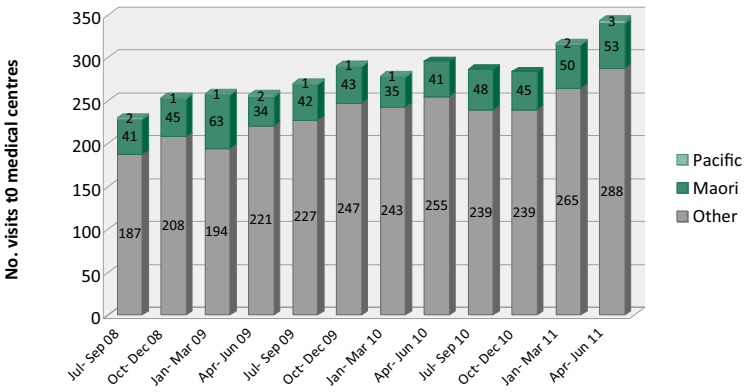
Progress 2010-2011

- This programme is well embedded in all primary practices and rural clinics as evidenced by the continued increase in activity over time.

Outcomes achieved

- The number of individual visits to practices this year increased by 96; 16% of visits were made by young Maori.
- The graph below shows the trend of increasing visits to practices over time:

Contraception and Sexual Health Visits



Expenditure

$25,640

5.8 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

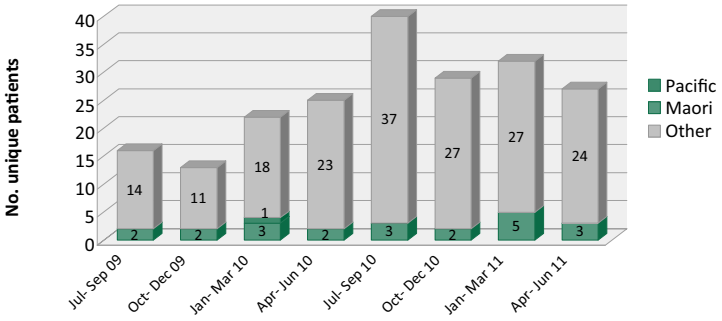
- funding of terminal care clinics and home visits.

Progress 2010-2011

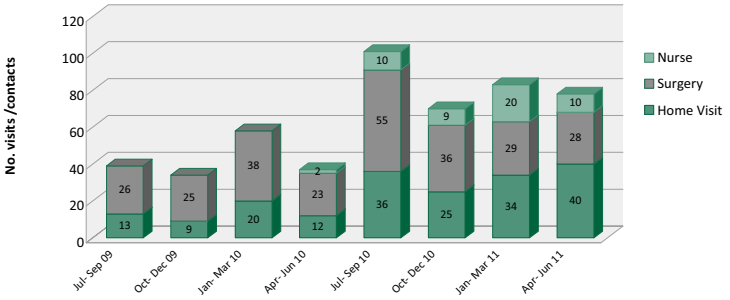
- This programme continues to cover the costs of visits to the general practice, home visits, virtual visits made on behalf of patients by palliative nurse specialists, and some part charges for medication used in a palliative setting for enrolled palliative care patients.

Outcomes achieved

Palliative Care Patients



Palliative Care Visits/Contacts by Type



Expenditure

$14,175

5.9 Mental Health

Aim

To support West Coast General Practice Teams (GPTs) to improve health outcomes and quality of life for people with mental health needs.

Target group

Enrolled patients of West Coast practices, 14 years of age and over, with mild to moderate mental health concerns.

Key activities

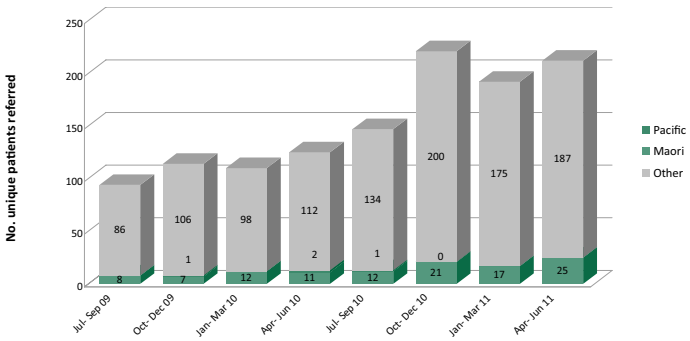
- Triaging of requests from GPTs and, in the case of young people, school counsellors and relevant social agencies. Assessments completed as appropriate.
- Provision of up to 6 fully-funded Brief Intervention Counselling (BIC) sessions (or up to ten sessions with young people) for those identified as meeting criteria.
- Facilitation of Extended Consultations by GPs and PNs with enrolled patients who have mental health issues.
- Education and assistance to GPTs in relation to mental health issues.
- Provision of workshops for primary health practitioners and other groups.

Progress 2010-2011

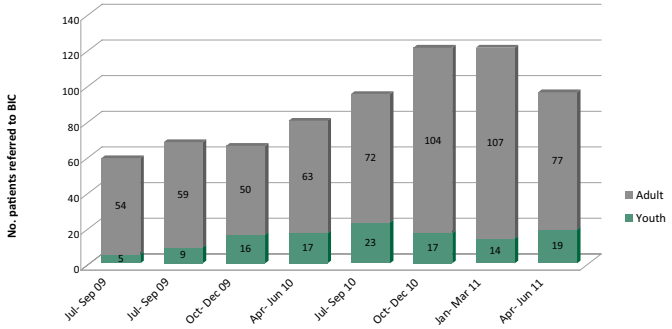
- A number of tragic events involved the team in various ways: September 2010 - the crash of a plane in Fox Glacier resulting in 9 deaths; November 2010 - the explosion at Pike River Mine with 29 deaths; February 2011 - an earthquake in Christchurch which caused 181 deaths, this quake being one of four which created considerable destruction in Canterbury.
- The Christchurch earthquake impacted in two ways: Christchurch residents who fled to the West Coast and were in need of support and counselling received services from the team (eligibility rules were temporarily relaxed), and West Coast residents affected by their close connections to people in Canterbury also received services.
- Assistance was given to the team by Canterbury DHB which provided personnel on a short-term basis, with additional funding being obtained from WCDHB to provide extra counselling capacity for six months.
- A registered Social Worker, joined the team in July 2010 to provide BIC to adults and young people; a Clinical Psychologist, joined the team initially to provide additional resources for Pike River support January-June 2011, and from May 2011 has been providing primary mental health services in South Westland.
- The mental health promotion tool, the 'cube', has proved extremely popular with people completing their BIC sessions, being a tangible reminder of some of the new skills they learned.
- The annual visit by the team to the practices took place in October-November 2010, this one being called 'the 2010 Rocky Roadshow - Going Bananas'. It continues to be a valuable occasion for two-way dialogue about the support the team can provide to practices in relation to their patients with mental health issues.
- There were many occasions to progress collaborative relationships with NGOs, e.g. Homebuilders, Richmond Activity Centre, PACT, Focus Trust, Warmline, as well as continuing to work with Community Mental Health teams to provide a more integrated and seamless service for people on the West Coast with mental health issues.
- After the resignation of a BIC counsellor in May 2011, three local Coast counsellors were temporarily contracted to the PHO and each provided counselling for four clients.
- Three team members received training as part of a national roll out of e-therapy provision for primary health practitioners using the evidence-based 'Beating the Blues', an online programme for mild to moderate depression.
- Team members continued to participate in training and other educational opportunities as well as receiving on-going supervision in what has proved to be a challenging year.

Outcomes achieved

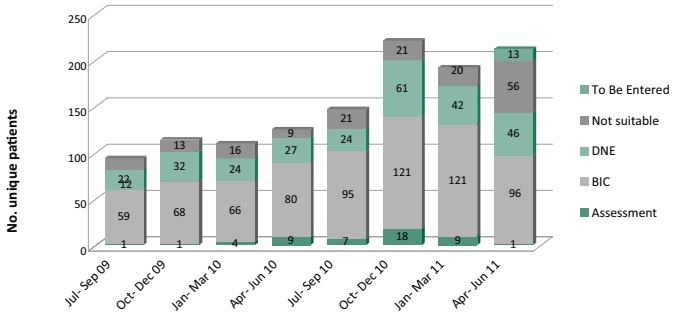
MH requests for assessment



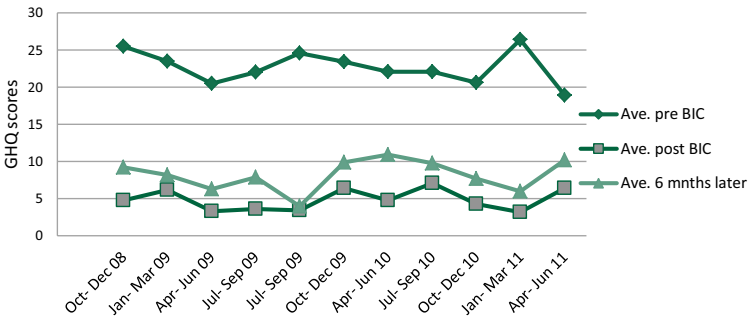
Patients - Brief Intervention Counselling



Treatment Pathway Upon Referral



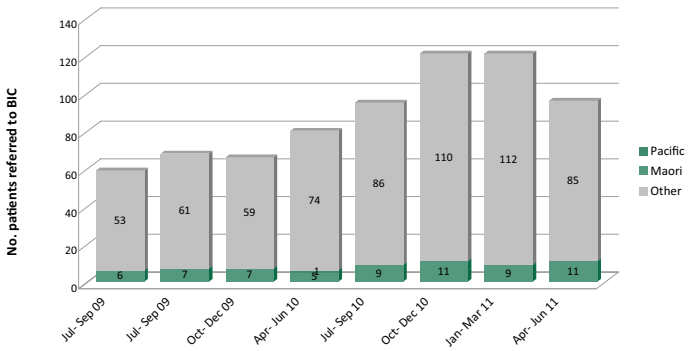
Patient Outcomes (change in GHQ scores)



To be entered = requests received but pathways being determined; Not suitable = not suitable for BIC but referred elsewhere; DNE = did not engage;

BIC = Brief Intervention Counselling;
Assessment = assessment only, further treatment not needed.

Patients - Brief intervention counselling (BIC)



The instrument used to obtain evaluation measures is the General Health Questionnaire (GHQ12). The scoring is on a scale 0 to 36, the higher the number, the greater the psychological distress. The GHQ is completed 3 times by people; before entering BIC, at the last counselling session, and at the follow-up session held at least six months after the last session. The Patient outcomes graph shows the data, indicating that the beneficial changes experienced by people undergoing BIC are sustainable over time.

Expenditure

$481,561 (Of revenue of $455,116 - the difference was made up from PHO reserved funds)

6. Quality Improvement and Professional Development

Expenditure

The PHO spent $923,692 on its various quality improvement and professional development support. Of this amount, $39,322 came from the PHO's reserved funds.

6.1 Workforce and rural support

Aim

To achieve the nationally agreed quality indicators

Target group

All PHO member practices.

Key activities

- Each practice has a functioning Quality Improvement Team which manages the programme.
- A Quality Improvement Plan is developed by each practice which guides the practices efforts for the year. This plan is submitted to the Clinical Governance Committee annually. This process fulfils the RNZCGP's Cornerstone objective E12.2.
- 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, their providers and the PHO. Locally collected data is now providing a more current picture of how practices are progressing towards the targets.
- Practice visits and group professional development sessions are held.
- Payments are available to support pharmacists to assist with cost effective and appropriate prescribing.
- The programme acts as a means to focus activities that support other programmes such as cervical and breast screening, as well as childhood and influenza immunisations.

Outcomes achieved

- Those indicators that are linked to the Long Term Conditions programme (namely, diabetes, heart disease and smoking) are reported in that section of this report.
- There have been positive trends in the majority of preventive health care indicators such as breast screening, cervical smears, immunisations and vaccinations, with the PHO exceeding the national rate in some of these indicators.
- Significant gains were made in relation to childhood immunisations for total population with the PHO exceeding the national rate for high needs population.
- For breast screening coverage (high needs population) the trend continues to improve and remains higher than the rate achieved nationally.
- Cervical screening rates for total population continue to improve but are just below the national rate. For high needs populations the trend is down marginally but better than the national rate.
- Vaccination coverage for those over 65 years continues to improve for total and high needs populations but is below the national rate.
- A quality improvement study day was held in May; a key focus of the day was on the reviewing and revising of the practices' quality improvement plans. For all practices a significant component of their quality improvement plan was related to improving relevant PHO Performance Programme (PPP) targets. 25 representatives from all three general practice professional groupings attended.

6.2 Professional and Practice Development

Aim

To encourage and support the continuing education and professional development of staff employed by all member practices.

Target group

All members of the general practice teams.

Key activities

- Professional development activities include local workshops and study days, local video linked evening education sessions, and funded access to conferences and training opportunities mostly outside of the West Coast.
- Practice development activities continue to centre on assisting practices with the RNZCGP Cornerstone practice accreditation programme.
- The Workforce Steering Group has been incorporated into the Core General Practice Workstream of the Better Sooner More Convenient initiative.
- Video conference capacity has increased with Franz Josef now linked into the system.

Outcome achieved

Local study days:

- 54 participants attended the Primary Health Day;

Smoking Cessation training:

- 2 Motivational Interviewing training days were held this year with 35 attendees;
- 2 Coast Quit smoking cessation and 1 advanced training day were held this year with 40 attendees;
- 1 type 2 diabetes study day, 15 attendees.

Continuing Medical Education (evening sessions):

- Dr Anna Dyzel continues as the contracted co-ordinator of the professional education programme and arranges the local inter-disciplinary education sessions in liaison with a team of representatives from each of the professional groupings.
- A total of 15 sessions were presented, with a total of 32 GP attendances and 135 nurse attendees and 24 practice administration attendees and 35 other attendees. The topics covered included the following: models of care, asthma, back, shoulder and knee exams, management of pain and management of common infections.

Conference/Course leave funded from quarterly allocations to practices:

- This was at a similar level to 2009/10.

Cornerstone practice accreditation:

- to date six practices/rural clinics are accredited, our target was 5;
- 1 practice is planning on accrediting before the end of 2011 under the original Cornerstone accreditation process;
- 1 practice deferred accreditation due to building work;
- a new version of the RNZCGP Standard for General Practice Aiming for Excellence 2011 was published in July 2011. Assessments to the new standard will commence from September 2011, with the funding arrangements for cycle 2 changing to a self-funding model.

6.3 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

Rural service providers contracted to the PHO.

Key activities

- reasonable and rural bonus payments to eligible service providers (all those outside of Greymouth) contracted to the PHO;
- 2 GP registrar scholarships available, to attract young GPs to the West Coast;
- ancillary support to practices (in extraordinary situations) for continuing of medical services;
- implementation of the after hours plan and its recommendations;
- 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.

Outcomes achieved

- Homecare Medical Ltd (HML) nurse triage service successfully implemented;
- standing orders training widely implemented across member practices;
- 1 GP registrar scholarship awarded;
- recruitment and retention plan was developed as part of the work of the Core General Practice work stream of BSMC, resulting in the establishment of a defined team to focus on retention and recruitment issues across all West Coast general practices;
- a practice workshop held on dealing with the stress of on-call, and several individual mentoring sessions provided.

7. Better, Sooner, More Convenient (BSMC)

Aim

To provide residents of the West Coast with better, sooner and more convenient (BSMC) primary care services at integrated family health centres (IFHC), and backed up with significantly improved integrated community delivered services ensuring quality and timely health care.

Target group

All West Coast residents are set to benefit from the introduction of IFHCs and integrated community health services.

Key Activities

The BSMC Business Case deliverables for the 2010/11 years focused on the development of a business case to justify the build of the IFHC in Westport/Buller. This focus resulted in the original 15 workstreams being collapsed into 6 workstreams; namely:

- Redesign of core general practice (including acute care, Maori health and workforce deliverables) to facilitate a change towards improved primary care services at IFHCs.
- Integration of DHB's current community services (includes community nursing, allied and mental health) into IFHCs.
- Develop and implement a model of care for Buller that will be the core of a future Westport IFHC.
- Develop and implement a model of care for Grey that will be the core of a future Grey IFHC which will include Grey regional hospital services
- Information Technology that will enable health professionals and health service providers to share important health information and therefore benefit the patient and the community as a whole.
- Governance and Ownership of services.

Outcomes Achieved

Although some of the outcomes below are across the West Coast, some are focussed on the Buller IFHC.

Core general practice:

- The introduction of Practice Quality Improvement by means of regular workshops and meetings for all general practices.
- The introduction of an after-hours phone triage system for all general practices.
- Key focus areas for recruitment and retention: in primary health care were identified, and the CDHB Human Resources team started working with local primary health care providers to develop and implement a recruitment and retention strategy.
- Progress is being made to recruit Maori health navigators and nurses for each practice. The first positions should be filled in Westport by the end of 2011.
- Standing Orders are now being used in 5 of the 8 general practices.
- A community education programme has been provided to all general practices.

Community Based Services:

- Multi- disciplinary team meetings in Westport and Reefton.
- The alignment of community nursing services to practice populations.
- Service specifications for an IFHC are being worked on and will require input from the Ministry of Health (MoH) as it relates to MoH reporting and audit requirements.
- A process for transfer of care (discharge planning from a hospital) to the IFHC is in development
- Work in conjunction with IT on improved IT services (as described below) continues.

Integrated Family Health Centres:

- Completion of academic practice on the Grey Base hospital site.
- Completion of the Franz Josef medical facility in conjunction with St John's ambulance services.
- Buller Joint Action Group (JAG) has met regularly and continues to provide input into the model of care for Buller and development of the business case to justify the new IFHC. Members of this group were also involved in a community forum, which gave the community an insight in to what was being done about IFHC. Development of a model of care for an IFHC in Buller is nearing completion.
- Early planning for a Greymouth IFHC has begun.

Information Technology:

- Achievement of deliverables has been delayed till mid to late 2011/2012, due to additional requirements. However, the Information Technology workstream has made good progress towards providing a user friendly system, as well as providing improved access to patient health information.
- Most of these improvements will be implemented in the 2011/2012 year.

Governance and Ownership:

- This workstream group had limited activity. Decision making about the governance and ownership of IFHCs was deferred to the 2011/12 year.

Whole of System approach to health care delivery:

- The West Coast PHO has continued to work closely with the DHB, and Community & Public Health and to develop health promotion and community action activities, under the Healthy West Coast banner.
- The Pike River Mine tragedy saw these organisations work together to rapidly develop a community support plan in response to the widespread natural distress in the community as a consequence of the disaster. The West Coast PHO joined the intersectoral response as part of the SIMS disaster response structure.
- The West Coast PHO and DHB have worked together closely in the implementation to the BSMC business case, particularly through the vehicle of the shared Alliance Leadership Team.

Expenditure

The PHO spent $239,522 on implementing the BSMC plan, of which $50,522 came from the PHO's reserved funds.

West Coast Primary Health Organisation Trust

Financial Statements
For the Year ended 30 June 2011

Financial Statements
West Coast Primary Health Organisation Trust

For the Year ended 30 June 2011

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

DIRECTORY

AS AT 30 JUNE 2011

PRINCIPAL BUSINESS:	Primary Health Organisation
ADDRESS:	PO Box 544 163 Mackay Street GREYMOUTH
TRUSTEES:	Trustees at 30 June 2011 John Boyes Anna Dyrel Maureen Pugh Tim Rochford Rosalie Sampson Tamai Sinclair (term completed 20 March 2011) Richard Wallace Tony Cot Helena Evers (resigned 5 April 2011) Franco's Tumahai (appointed 24 February 2011) Toni Caldwell (appointed 28 April 2011)
INDEPENDENT CHAIRPERSON:	John Ayling
AUDITORS:	WHK DUNEDIN
SOLICITORS:	Hannan & Seddon GREYMOUTH
BANK:	Westpac Bank

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2011

	Consolidated 2011 $	Consolidated 2010 $	Parent 2011 $	Parent 2010 $
INCOME				
Revenue	8,179,204	8,475,632	8,184,688	8,475,632
Interest Received	57,745	43,027	57,748	55,513
Sundry Income	23,274	201,135	23,274	100,236
Depreciation Recovered	7,624	-	7,624	-
TOTAL OPERATING INCOME	8,263,850	8,719,694	8,188,334	8,631,291
OPERATING EXPENSES				
Donation	7,299	1,000	250	1,000
Audit Fee	11,419	10,366	11,419	10,366
Bad Debts	5,758	-	5,758	-
Bank Fees	3,289	3,070	902	927
Contract Payments	6,659,001	6,801,364	6,659,001	7,209,648
Directors Fees	6,700	13,125		
Insurance	6,874	7,344	6,002	6,431
Interest Expense	6,762	5,200	-	-
Leases	126,009	153,691	116,676	124,620
Loss on Disposal of Asset	87,461	-	17,821	-
Other Expenses	267,280	273,562	302,733	269,733
Telecommunications	51,515	39,648	49,002	32,584
Salaries & Wages	974,091	1,151,788	915,226	850,902
Trustee Meeting Fees	70,184	69,562	70,184	69,562
Trustee Reimbursements	12,639	7,451	12,639	7,451
Depreciation	72,552	89,446	72,552	62,803
Impairment Adjustment	-	41,000	176,279	207,990
	8,474,738	8,766,626	8,425,464	8,654,571
NET DEFICIT FOR THE YEAR	(211,888)	(46,932)	(237,130)	(23,280)
Tax Expense	10,800	-	-	-
DEFICIT FOR THE YEAR AFTER TAX	(222,688)	(46,932)	(237,130)	(23,280)

WEST COST PRIMARY HEALTH ORGANISATION TRUST

STATEMENT OF MOVEMENTS IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2011

	Consolidated 2011 $	Consolidated 2010 $	Parent 2011 $	Parent 2010 $
Net Deficit for the Year	(222,688)	(46,932)	(237,130)	(23,290)
TOTAL RECOGNISED REVENUE AND EXPENSES	(222,688)	(46,932)	(237,130)	(23,290)
Equity at Beginning of Year	815,182	862,114	840,424	863,714
EQUITY AT THE END OF THE YEAR	592,494	815,182	603,294	840,424

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2011

	Note	Consolidated 2011 $	Consolidated 2010 $	Parent 2011 $	Parent 2010 $
EQUITY	4	**592,494**	**815,182**	**603,294**	**840,424**
Represented By:					
CURRENT ASSETS					
Westpac Bank		53,272	483,125	53,272	483,125
Westpac Bank Saver		1,259,930	1,226,268	1,259,930	1,226,268
Accounts Receivable		159,562	234,506	174,585	331,677
Cash on Hand		-	100	-	-
Petty Cash		115	179	115	79
Prepayments		4,947	4,352	4,942	4,352
GST Refundable		9,098	-	4,076	-
TOTAL CURRENT ASSETS		1,496,923	2,028,580	1,496,923	2,044,501
NON-CURRENT ASSETS					
Property, Plant & Equipment	7	181,584	300,356	181,584	204,236
TOTAL NON-CURRENT ASSETS		181,584	300,356	181,584	204,236
TOTAL ASSETS		**1,678,507**	**2,328,936**	**1,678,507**	**2,235,737**
CURRENT LIABILITIES					
Westpac Bank		-	96,885	-	-
Trade creditors		305,590	496,727	305,920	477,432
GST Payable		-	2,986	-	727
Received Funding		727,751	880,549	727,751	880,549
Employee Entitlements		41,572	34,605	41,572	36,605
Provision for Taxes		10,800	-	-	-
TOTAL CURRENT LIABILITIES		**1,086,013**	**1,513,754**	**1,075,213**	**1,395,313**
NET ASSETS		**592,494**	**815,182**	**603,294**	**840,424**

For and on behalf of the Trustees

Trustee

Date 17-10-11

Trustee

Date 17-10-11

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2011

1 STATEMENT OF ACCOUNTING POLICIES

The financial statements presented are for the reporting entity West Coast Primary Health Organisation Trust (the PHOT). The PHO has been constituted 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.

The income tax recognised in the Consolidated Statement of Financial Performance is the estimated income tax payable in the current year which reflects Greymouth Family Health Centre Limited's income taxable by, adjusted for any differences between the estimated and actual income tax payable in prior years.

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.

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.

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2011

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% - 60% DV
Motor Vehicles	30% DV
IT, Plant and Furniture	9.6% - 50% 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. Inter-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 and ceased trading on 10 September 2010.

CHANGES IN ACCOUNTING POLICIES

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

2 RELATED PARTIES

The following Trustees received payment 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 West Coast 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 (2010: NIL) as at balance date.

There were no contingent liabilities as at balance date (2010: NIL).

WHK

M.P.

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2011

4 TRUST EQUITY

	Consolidated 2011 $	Consolidated 2010 $	Parent 2011 $	Parent 2010 $
Retained Earnings				
Retained Earnings at Start of Year	65,182	862,714	90,424	863,714
Net Deficit For The Year	(222,688)	(46,932)	(237,130)	(23,290)
Transfer from / (to) BSMC Reserve	750,000	(750,000)	750,000	(750,000)
Retained Earnings at End of Year	592,494	65,182	603,294	90,424
BSMC Reserve				
Reserve at Start of Year	750,000	-	750,000	-
Transfer from / (to) Retained Earnings	(750,000)	750,000	(750,000)	750,000
Reserve at End of Year	-	750,000	-	750,000
TOTAL TRUST EQUITY	**592,494**	**815,182**	**603,294**	**840,424**

The BSMC Reserve was created in the 2010 financial year to recognised the funds required to implement (over three years) the BSMC business case which had been approved by the Ministry of Health, as well as by the West Coast DHB.

During the year to June 2011 the Trustees have transferred this balance back to retained earnings from where future BSMC costs will be funded.

5 NON-CANCELLABLE OPERATING LEASE COMMITMENTS

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

	2011	2010
Current Portion	51,933	95,786
Non-Current Portion	65,036	47,601
	116,969	143,387

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. This guarantee ceased on 31 January 2011

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2011

7 PROPERTY, PLANT & EQUIPMENT

Parent - 2010	Cost	Depn	Accum Depn	2011 Bk Value
Building Improvements	86,563	10,833	43,100	43,463
Motor Vehicles	39,303	8,905	19,462	19,843
IT & Plant	232,081	43,799	91,151	140,930
	357,949	63,137	153,713	204,236

Consolidated - 2010	Cost	Depn	Accum Depn	2010 Bk 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	93,656	149,367
	480,475	89,445	180,121	300,356

Parent - 2011	Cost	Depn	Accum Depn	2011 Bk Value
Building Improvements	86,563	7,819	50,919	35,644
Motor Vehicles	35,045	6,925	8,785	27,260
IT & Plant	247,400	57,809	128,720	118,680
	367,006	72,552	185,422	181,584

Consolidated - 2011	Cost	Depn	Accum Depn	2011 Bk Value
Building Improvements	86,563	7,819	50,919	35,644
Motor Vehicles	35,045	6,925	8,785	27,260
IT & Plant	247,400	57,809	128,720	118,680
	367,006	72,552	188,422	181,584

8 EVENTS SUBSEQUENT TO BALANCE DATE

The Trust's subsidiary company, Greymouth Family Health Centre Limited, is in the process of being wound up.

WHK

INDEPENDENT AUDITOR'S REPORT

To the Trustees of the West Coast Primary Health Organisation Trust

Report on the Consolidated Financial Statements

We have audited the consolidated financial statements of the West Coast Primary Health Organisation Trust and its subsidiary on pages 2 to 8, which comprise the Statement of Financial Position as at 30 June 2011, the Statement of Financial Performance, and Statement of Movements in Equity for the year then ended, and a summary of significant accounting policies and other explanatory information.

Trustee's Responsibility for the Consolidated Financial Statements

The Trustees are responsible for the preparation and fair presentation of these consolidated financial statements in accordance with generally accepted accounting practice in New Zealand; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates, as well as evaluating the overall presentation of the consolidated financial statements.

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

Other than in our capacity as auditor we have no relationship with, or interests in, the West Coast Primary Health Organisation Trust or its subsidiary.

Opinion

In our opinion the financial statements on pages 2 to 8 present fairly, in all material respects, the financial position of the West Coast Primary Health Organisation Trust and group as at 30 June 2011 and its financial performance for the year then ended, in accordance with generally accepted accounting practice in New Zealand.

WHK

17 October 2011

Dunedin
CHARTERED ACCOUNTANTS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