ANNUAL REPORT

2011 - 2012

West Coast
Te Tai o Poutini
Primary Health

CONTENTS

TRUSTEES REPORT

Trustees take pleasure in presenting the Annual Report and Financial Statements for the year ended 30th June 2012.

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, for a range of primary health care services to the people of the West Coast who are enrolled with a medical centre. 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 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 the intention of both organisations to work towards 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 assessments services and allied health. Implementation is now under way.

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 committee and in particular its Chair, Dr Greville Wood.

With respect to our funding position, Trustees again decided to apply reserves and savings from previous years to continue a number of services targeting 'at risk' populations. These included supporting practices for patients enrolled in the 'Long Term Conditions Programme', and assisting the general practices with our primary mental health service and our 'Keeping People Healthy' programme. The net result of these and other contracted services is a deficit of $54,901, which has been funded from reserves.

During the year the WCDHB further developed and commenced its proposals for a 'providing a West Coast health system that supports our community to be well within the allocated resource'. There are some implications for the PHO with respect to its role and function which will be addressed with the District Health Board during the forthcoming year.

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	7
John Boyes	7
Toni Caldwell	6
Tony Coll	6
Anna Dyzel	6
Maureen Pugh	6
Tim Rochford	2
Rosalie Sampson	5
Francois Tumahai	5
Richard Wallace	4

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 to 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 Board of Trustees

John Ayling
Chair

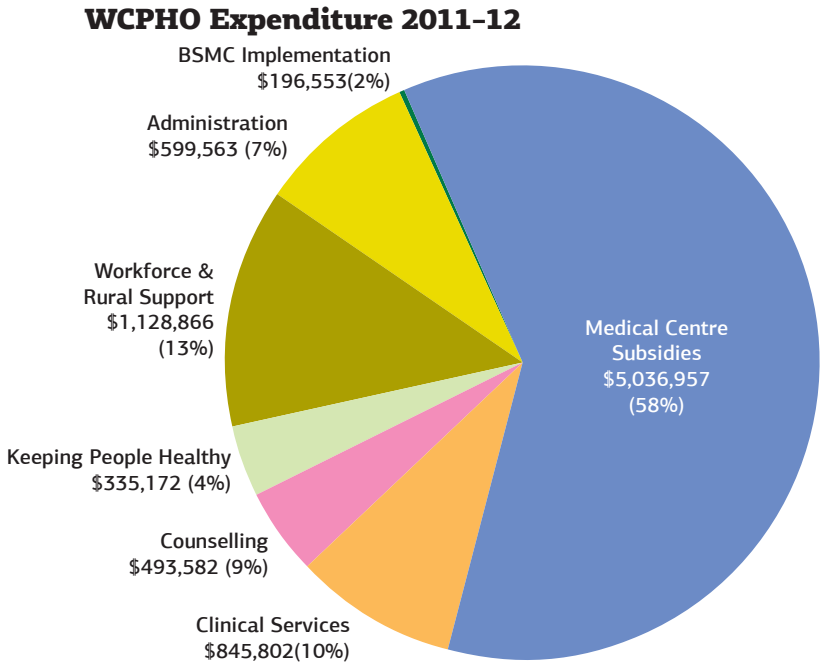
PHO Board and CEO: *Back row, left to right, Anthony Cooke (CEO), Tony Coll, John Ayling (Chair), John Boyes and Richard Wallace. Front row, left to right, Rosalie Sampson, Toni Caldwell and Maureen Pugh. Not present: Anna Dyzel, Francois Tumahai and Tim Rochford.*

MANAGEMENT REPORT

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

1. it provides funds to, and otherwise supports, the provision of primary health care, predominately through the region's medical centres (or general practices);
2. it directly provides some primary health care services itself, again in ways that work in with, and support, the work of the general practice teams;
3. it educates the community about staying healthy.

Its money is invested in the following areas and proportions:



The PHO ended the year with a deficit of $54,901, although it is important to note that this was after the transfer of $310,631 from the PHO's reserves accumulated in previous years. Without those transfers, the PHO's deficit would have been $365,532. As a result the PHO's reserves have reduced from $727,751 at the start of the financial year to $417,120 at the end of the financial year.

Highlights for the 2011-12 year:

- The "GP weekend away". This inaugural education and networking event was held at Punakaiki in August with General Practitioners (GPs) and Rural Nurse Specialists (RNSs) attending. There were a variety of professional development opportunities for attendees and also the chance to catch up and network and share experiences with colleagues across the West Coast in a less formal setting. Feedback was all positive, including the suggestion to wait another year for another event may be too long and perhaps the next one should be sooner!
- The PHO's 2012 calendar, featuring twelve key health promotion campaigns accompanied by the relevant health related personal stories of West Coasters, was delivered to every household on the West Coast. This key initiative was designed to keep health priorities at the top of people's minds and to encourage them to proactively manage their health.
- In March the 1000th client started in the Green Prescription programme. This programme improves the health outcomes and quality of life for West Coasters by supporting and empowering them to exercise regularly as an integral part of their lives.
- Coast Quit smoking cessation programme exceeded all expectations with 605 enrolments which far exceeded the 250 funded places.
- In the April to June quarter the Mental Health team reached the milestone of working with the 3000th West Coaster. The team support West Coast General

Practice Teams (GPTs) to improve health outcomes and the quality of life for people with mild to moderate mental health issues.

We regularly publish data from our different projects showing performance trends over time. The results from much of the work we do are difficult to measure or the timeframes too short for real results to emerge. It takes a long time for the life expectancy of an entire region's population to change; and there are many factors outside the health sector that affect life expectancy.

However, a preliminary evaluation of diabetes outcomes for patients who have had at least two diabetes annual reviews shows the following: of 983 individuals for whom data is available, 244 had a starting HbA1c >=8 (i.e., their blood sugar was not well controlled) and, five years later on average, 190 had a lower HbA1c score and a further 8 individuals had not got worse.

The average HbA1c became 1.9 lower (average moved from 10.0 to 8.1) over an average of 5 years.

So what does this mean? It means there are now nearly 200 West Coasters for whom the natural progression of their disease has been halted over a 5 year period due to the efforts of patients themselves combined with the work of their doctors and nurses and other health professionals in the practices and PHO. This will have reduced some of the complications from diabetes that would otherwise have occurred, such as foot amputations, blindness, heart attacks and strokes.

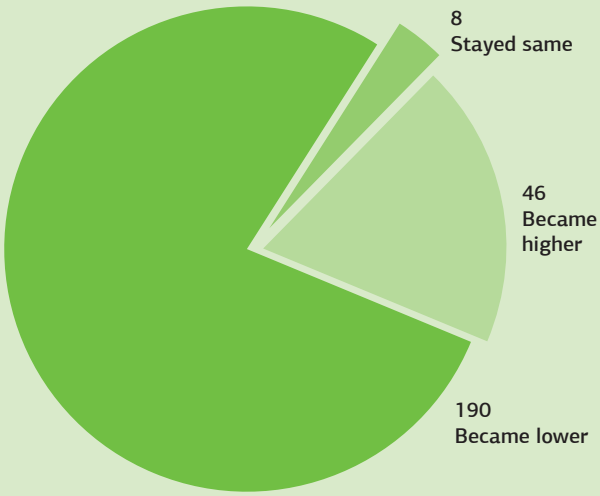
It's encouraging to know our efforts are making a difference in the quality of health in people's lives. It is also inspiring for us to see these results and recognise how we make a difference.

So, on that note, I'd like to record my thanks to all the hard working and imaginative staff of the PHO, to the Trustees who have trusted and empowered me and to the general practice teams and to other colleagues throughout the West Coast health system who have helped deliver the results documented in this annual report. You will see towards the end of the report that we have included a page of some of the groups and networks we work with to achieve these outcomes. It truly is a collaborative process of Coasters supporting Coasters.

Finally, I'd also like to acknowledge and thank those who have heard the messages about how their level of health and wellbeing rests, to a significant extent, in their own hands. They are the managers of their own health future and our health professionals will continue to advise, diagnose, and treat, but it is the patients, their families and our communities who are the ones who eat healthily and stay physically active.

Anthony Cooke
Chief Executive

Outcomes for 244 patients with initial HbA1c >=8



Change in HbA1c over five years at WCPHO

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 2011-2012

- 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 2011-12

Under 6 yrs	$ 0.00
6 to 17 yrs	$11.50
Adult	$17.00

Outcomes measured

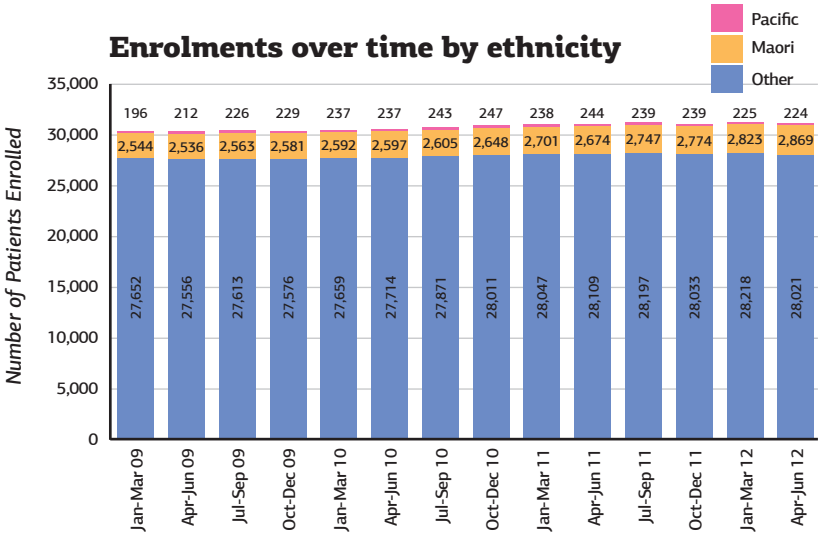
On average, the PHO had 31,202 patients enrolled during the financial year. The number of enrolled patients increased slightly from 31,183 during the first quarter (Jul-Sep 11) to 31,312 during the last quarter (Apr-Jun 12).

The PHO subsidised 123,926 visits by enrolled patients to its contracted medical centres during the year. This was down on the 130,923 visits in 2010-11 year, but similar to the 122,254 and 119,933 in the immediately prior years.

This represents an average of 4.0 visits for each enrolled patient in the PHO. The average subsidy for each enrolled patient was therefore $185.65 (including GST) during the year, while the average subsidy per patient visit was $46.74 (including GST).

Expenditure

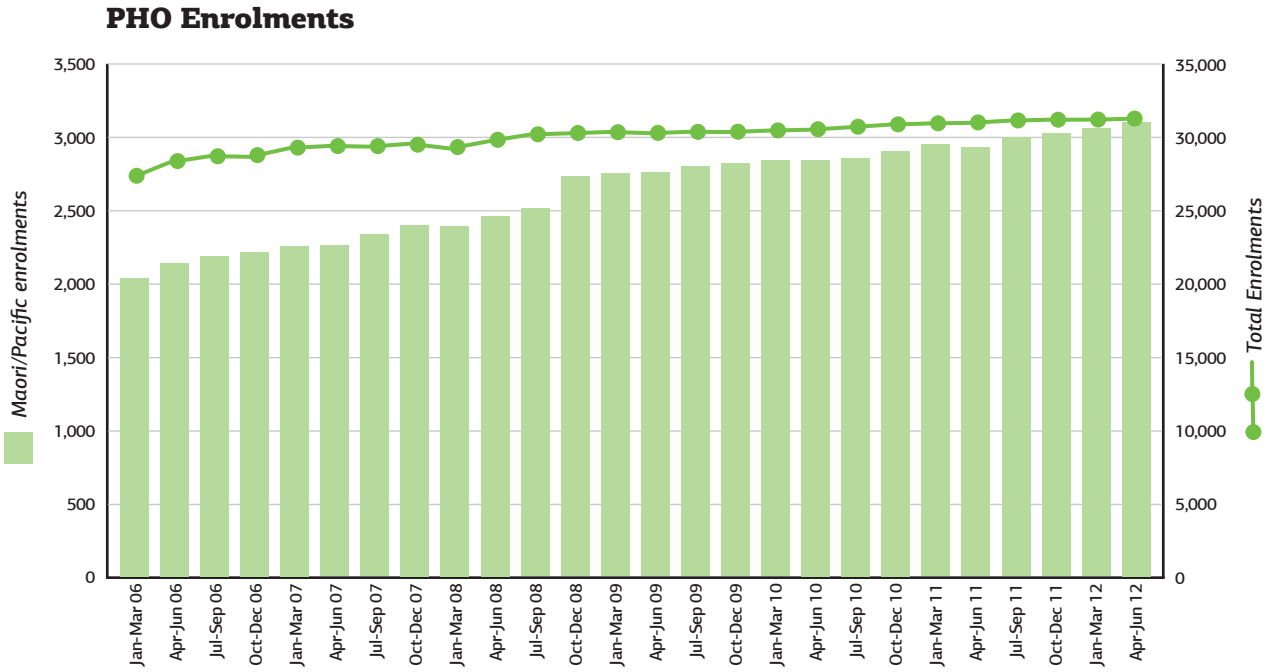
$5,036,957 (excl. GST)



ACCESS FOR MAORI

Over the past 26 quarters, enrolments in the PHO by Maori and Pacific Island people have grown 52%, while those by people of all other ethnicities have grown 15%.

Maori and Pacific people 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.



WHY THE PHO DOES WHAT IT DOES

The Western world faces an epidemic of long term conditions, including diseases such as diabetes and cardio-vascular 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.

Communicable diseases were inexplicable to ancient and medieval humans. It seemed as though random events – the gods/God being angry, a curse invoked by a neighbour, a visit by a foreigner – had explanatory value as great as any other. Then we discovered the germ theory of medicine, the value of cleanliness, hand-washing, sanitation and sewerage systems. By controlling our environment, by public health requirements in our built environment, we have largely eliminated the impact of many of these communicable diseases. We now insist on public sanitation standards - we know the importance of clean water, sanitation systems etc.

The modern Western civilised world grew out of a past in which famine was all too common and lives were blighted and damaged by hard physical labour, just to make ends meet. In the Western world, we no longer typically have a problem with famine or grinding manual labour and its associated accidents. But in our elimination of food shortages, and our substitution of mechanical and electronic aids for physical labour, we have set up another set of health problems for which our bodies are not adapted by our evolutionary past.

Chronic conditions in the Western world arise 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).

We know bubonic plague was caused by bacteria transmitted by fleas carried by rats. We no longer allow rats to roam free through our homes and kitchens. We make sure garbage is collected and disposed of appropriately to keep rats at bay.

We know that chronic conditions are caused by foods laced with fat, sugar and salt, combined with cars, remote controls, labour saving devices, computers and the other enablers of physically inactive lifestyles. And yet, as a society, we continue to permit these drivers of the very diseases we face.

We (humans) have not yet outlawed the addition of unnecessary fat, salt and sugar to food. We will, eventually, just as we outlawed rats in kitchens.

The rising tide of chronic conditions is entirely explicable; they are caused by our modern, civilised lives. In the PHO, in our medical centres and in our hospitals, we deal every day with the results of decades of this modern living.

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:

1. promoting healthy lifestyles (more fresh fruit and vegetables, more physical activity, less fat, salt and sugar, stop smoking) to the entire community;
2. screening certain groups within our community we know are likely to be at risk of developing chronic conditions e.g. every woman over 55, every man over 45, and for Maori every woman over 45 and every man over 35 for diabetes and heart disease;
3. working with those identified through that screening process as being at high risk (defined as >15% likelihood of a heart attack or similar within the next five years) to reduce their level of risk;
4. working with those identified as actually having one of the chronic diseases (diabetes, cardio-vascular disease, chronic obstructive pulmonary disease) to support them to live well with their conditions and reduce complication rates.

KEEPING PEOPLE HEALTHY

Expenditure

The PHO spent $335,172 on the various 'Keeping People Healthy' programmes.

Green Prescription

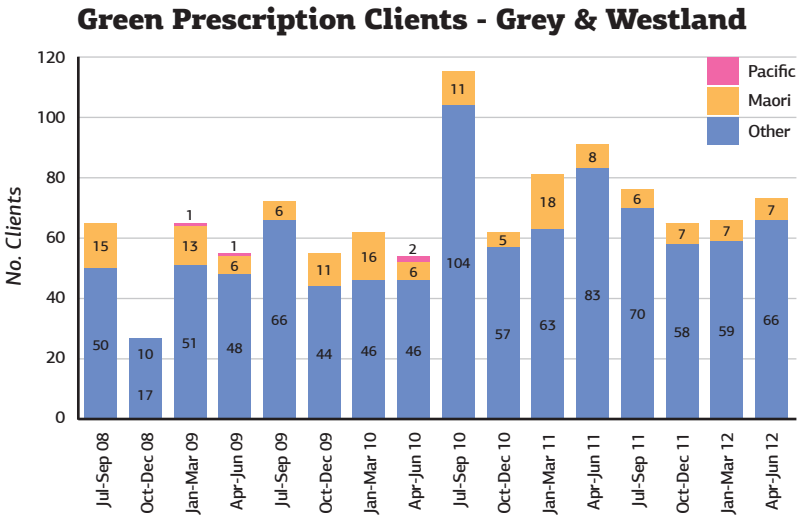
Aim

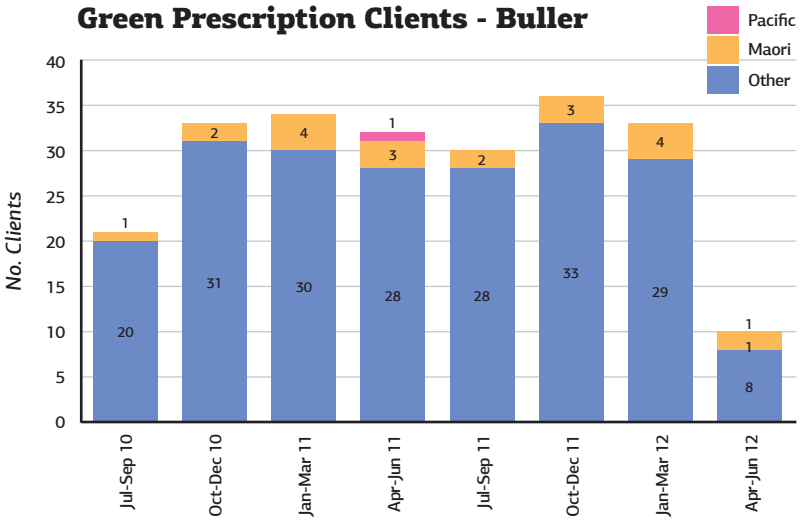
To improve health outcomes and quality of life for West Coasters by supporting and empowering them to exercise regularly as an integral part of their lives.

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.





The Apr-Jun numbers are lower than anticipated due to the coordinator resigning and not being immediately replaced. There had been uncertainty as to whether the funding would be continued beyond June 2012; once funding was assured, the service was resumed (from July 2012).

Key activities

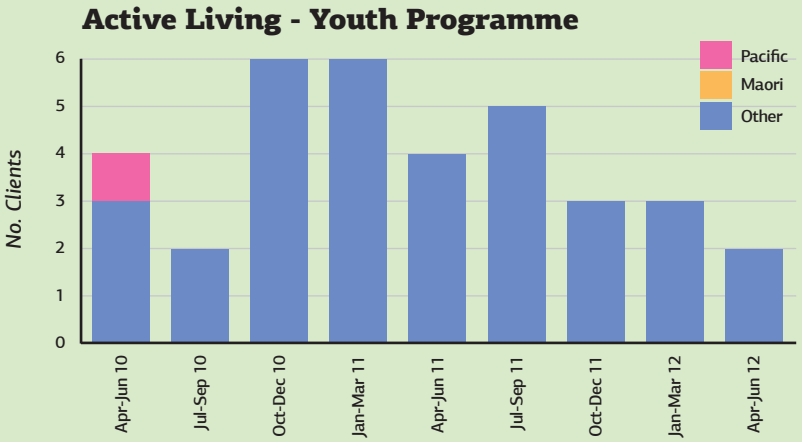
- providing individual exercise programmes to enable people to exercise at home, achieved by an initial face-to-face visit and then supported by telephone follow-up over a four month period;
- individual or group exercise sessions in Greymouth, Hokitika, Westport and Reefton to familiarise people with gym equipment and for meeting other Green Prescription clients;
- 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. This programme will cease from 31 July 2012 due to the discontinuation of HEHA funding.

Progress 2011-2012

- The popularity of this programme on the West Coast has surpassed expectations. In March 2012 the 1000th person commenced the programme since its inception in 2008.
- The Active Youth programme was of enormous benefit to a small number of at-risk youth.
- Regular Green Prescription newsletters and updates are sent to all practices.

Outcomes achieved

- 280 referrals were received in the 2011/12 year for Grey & Westland; 9.6% were for Maori.
- 109 referrals were received in the 2011/12 year for Buller; 9% were for Maori.
- The graph shows the number of Green Prescription youth enrolled since the programme began:



Breastfeeding Support

Aim

To improve breastfeeding rates and create a supportive breastfeeding environment on the West Coast (because the evidence is that breastfeeding is good for infants and, in fact, contributes to lifelong good health).

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

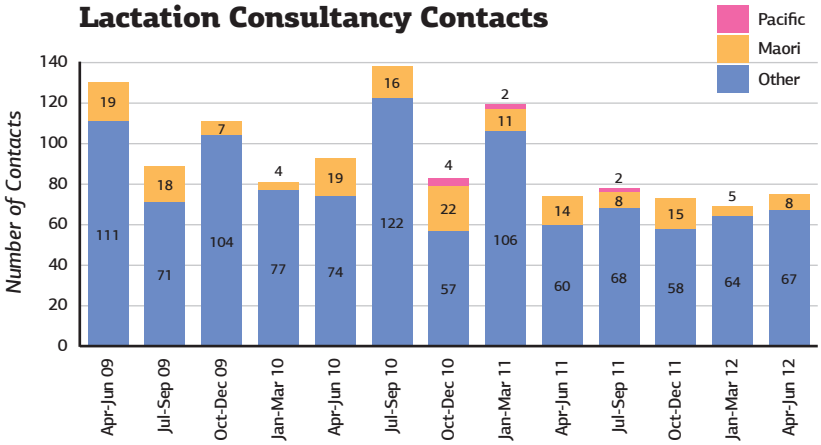
- peer counsellor (Mum4Mum) training and support;
- lactation consultancy;
- breastfeeding education sessions;
- networking and collaboration with the DHB, primary health sector and community;
- community promotional activities and advocacy.

Progress and outcomes 2011-12

- Previously the breastfeeding rates have been determined exclusively from Plunket data. This year's data is captured from Plunket, Rata Te Awhina Trust and the West Coast DHB, thus results are not comparable to previous years. The breastfeeding rates at 6 weeks: 75% for Maori (target 81%) and 77% overall (target 74%), and at 6 months, 28% for Maori (target 32%) and 39% overall (target 39%).

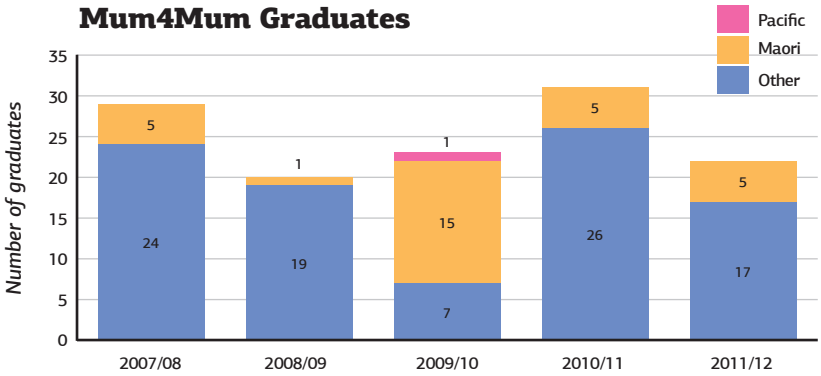
Lactation consultancy:

- 103 clients with the following profile: 65 decile 8-10; 29 rural; and 15 less than 20 years of age.
- Of the 348 contacts this year, 10% were with Maori mums.



Peer support:

- at least 80 women were supported by Mum4Mums, formally and informally;
- Mum4Mum peer support counsellor training programmes were held twice in Greymouth and once in Westport, with 22 graduating women; 5% were Maori;
- regular Mum4Mum involvement with ante-natal breastfeeding classes;
- regular support provided to Mum4Mums through meetings, newsletters and education sessions.



Breastfeeding education sessions:

- breastfeeding sessions held at ante-natal classes (Hokitika 1, Greymouth 5, Westport 4);
- a breastfeeding education day with Carol Bartle (IBCLC, RN, RM, MHSc) was held in Greymouth with 30 attendees and a half day held in Westport with 11 attendees;
- education sessions for clinical staff were held at Westland Medical Centre, Greymouth Medical Centre and High Street Medical Centre.

Networking, promotion and advocacy:

- social networking through a 'West Coast Breastfeeding' page used to connect West Coast women and promote breastfeeding support groups and other local events;
- development and near-completion of the West Coast Breastfeeding Handbook in conjunction with West Coast DHB;
- World Breastfeeding Week and The Big Latch On promotion during August 2011 to community and general practice teams;
- active involvement with many agencies and individuals in the health sector and the wider community, including Maori.

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 2011-2012

The West Coast PHO 2012 calendar was launched and distributed to 13,300 households in December 2011, featuring 'Rusty' the health promotion mascot and his tips for good health.

Men's Health Awareness:

The focus this year was to support practice teams to engage with their enrolled population of 'high need' men who had not had their cardiovascular risk assessment and diabetes check completed. High Street Medical Centre held an after-hours men's clinic with 14 attendees, 64% were of Maori, Pacific or Indian ethnicity. In June 2012, 'Get the Tools – the Nuts & Bolts of Men's Health' website was launched and promoted collaboratively with the Cancer Society across the West Coast. A men's health promotional stall was at the Agfest 2012 held in Hokitika, again in conjunction with the Cancer Society.

Smokefree May:

In conjunction with Community & Public Health, the Cancer Society, and the West Coast Smokefree Coalition, there was extensive promotion in practices, pharmacies, community and local media for Smokefree May across all three districts.

Diabetes Awareness month:

During November the promotion of diabetes prevention and early detection throughout the practices and pharmacies used the 'sweet as' theme. In conjunction with the Local Diabetes Team a full page promotional spread appeared in the Messenger newspaper, as well as on the PHO website.

Heart Month:

Heart month was held in February with many collaborative activities celebrated in practices, pharmacies and the community across the West Coast. The aim was to increase the number of eligible men and women getting their 5 year cardiovascular risk assessed.

Influenza Vaccination Promotion:

All practices held dedicated 'flu' clinics beginning in March 2012. Practices were encouraged to identify eligible people and 'invite them in' to have their free flu shots. A 65+ flu clinic and older adult expo was held in Westport in April with 21 stalls from local groups displaying their services; 51 people over 65 years received their free seasonal flu vaccination at this event.

Childhood Immunisation Poster Campaign:

An innovative and endearing promotion of a new West Coast themed immunisation poster featuring 80 local children, all fully immunised, was launched in May. Four different posters were created and distributed widely across the West Coast.

Other community collaborative health promotion initiatives included:

- The Big Latch On during World Breastfeeding week; Cancer Society Relay For Life; Children's Day in Hokitika; Daffodil Day; Cervical Screening Month, and Mental Health Awareness Month in October 2011.
- Healthy Lifestyle Ambassador Awards were presented to individuals in Westland, Grey and Buller districts.

CLINICAL PROGRAMMES AND SERVICES

Screening for Cardiovascular Disease and Diabetes

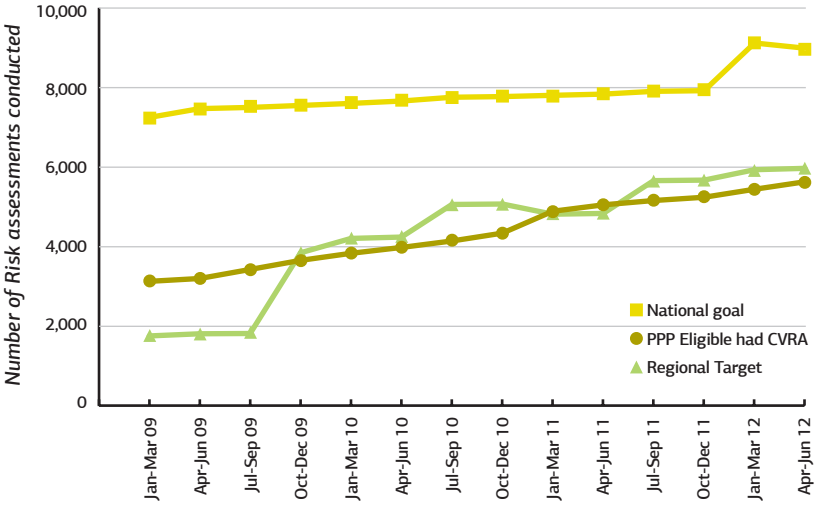
Aim

To identify individuals at high risk of a cardiovascular event (heart attack or stroke) and diabetes, with a view to providing appropriate patient management and support to decrease their risk, so as to reduce the incidence of heart disease and stroke.

Target group

All individuals recommended for screening by the New Zealand Primary Care Handbook - Cardiovascular Risk Assessment and Diabetes Screening, with particular emphasis on high need groups including Maori and Pacific.

CV Risk Assessments Conducted in Each Quarter



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 individuals 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;
- to ensure that individuals identified with high risk have an annual assessment of their risk level;
- to increase physical activity; to decrease smoking, blood pressure, lipid levels and Body Mass Index (BMI), and hence to reduce overall cardiovascular risk in these individuals;
- to decrease inequalities in treatment and in outcomes between high need groups and the rest of the population at risk.
- During the year 10% of all risk assessments completed were for Maori.
- 83% of those screened were non-smokers.

Progress 2011-2012

- Practice nurses and General Practitioners are routinely providing cardiovascular risk screening with emphasis on high need groups, including Maori and Pacific.
- All identified current smokers are given brief advice to stop smoking, with many referred to smoking cessation services.
- From 1st July 2011, all cardiovascular risk assessments were subsidised and made free to patients for their 5 year checks, including their follow-up visit if their risk was >15%.
- Practice teams are actively identifying eligible patients and inviting them in for their cardiovascular risk assessment.

Outcomes achieved

- 1,465 risk assessments were completed. Risk assessments included all initial assessments and annual follow-ups for those identified with high risk.
- 57% of the eligible West Coast population have now been screened. The target was to reach 60% by 1st July 2012; the National goal is to reach 90% by July 2014.

Expenditure

$16,394

Treatment for Those Identified with High Cardiovascular Risk

Aim

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

Target group

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

Key activities

- all identified smokers are given brief advice and support to quit;
- recommending lifestyle interventions: diet, physical activity and weight management advice given and referrals made to relevant primary care providers;
- optimal pharmacological treatment is commenced;
- regular follow-up monitoring of cardiovascular risk.

Progress and outcomes 2011-2012

- Of the 1465 screens conducted (see previous section), 339 individuals (23%) were identified as having 15% or greater risk of a cardiovascular event.
- In conjunction with the Cardiac Society of Australia and New Zealand (CSANZ), a study day for clinicians was held, focusing on management of people identified with increased risk.
- Many people with high risk are referred to Green Prescription to help them become more active as part of their lifestyle change.

Expenditure

$21,859

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).

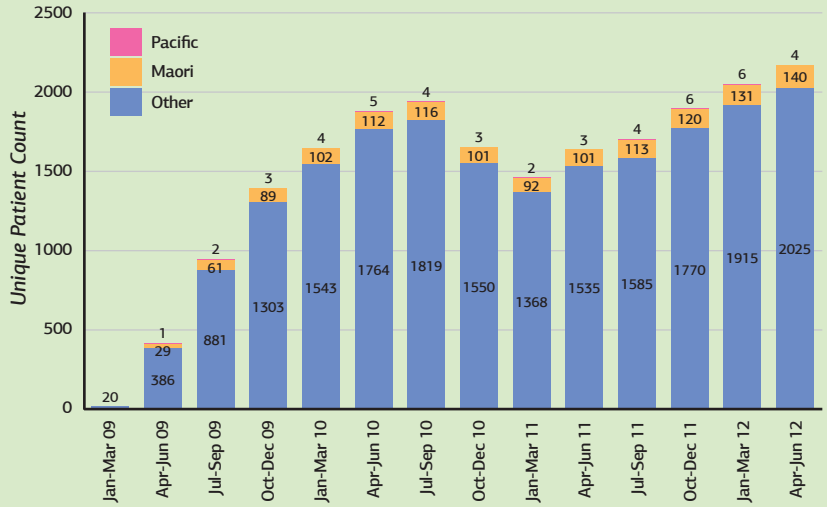
Target group

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 then for patients to receive a package of care based on their 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.

Enrolments in the long term conditions programme



Progress 2011-2012

- The Health Navigator service is now well embedded as part of 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.
- Many practices now have nurse-led clinics for LTC patient management.
- Practice Quality Improvement teams receive quarterly reports on their progress and activity for the LTC programme.

Outcomes achieved

- 2169 people were enrolled in the LTC programme by the end of the financial year, which means 6.9% of the PHO's enrolled population is engaged in a structured programme of care for their long term condition(s).
- Maori make up 6.4% of all enrolments in the programme to date. For comparison, Maori make up 5.2% of the enrolled population aged 45+ years – the prime age group of people in the LTC programme.

This graph shows the number of individuals enrolled since the programme began.

Source of funding

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

Expenditure

$180,930

Care for People with Cardiovascular Disease

Aim

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

Target group

All patients with established cardiovascular disease, including angina, myocardial infarction, peripheral vascular disease, post revascularisation, ischaemic stroke or transient ischaemic attacks.

Key activities

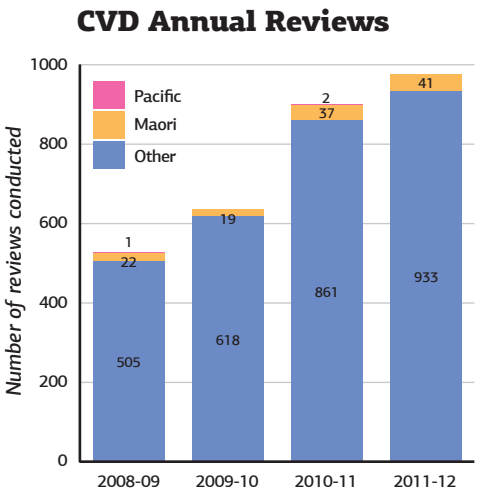
- to identify all patients with cardiovascular disease (CVD);
- to provide an annual review for all enrolled patients with established CVD;
- to reduce inequalities in treatment and health outcomes between high need groups and the rest of the population with CVD;
- to ensure that these patients are receiving 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 2011-2012

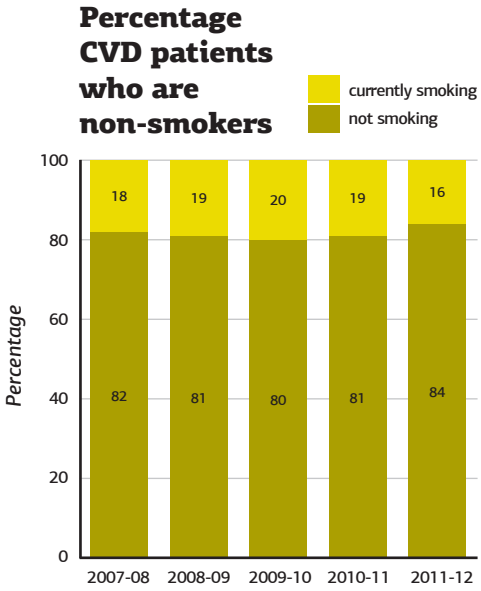
- CVD annual reviews are a routine aspect of planned care as part of the Long Term Conditions programme. Patients are receiving individualised care based on their clinical needs as well as their ability to self-manage their condition.
- Cardiac Nurse Specialists' support is an adjunct to care of patients with CVD.
- All identified smokers are offered brief advice and support to quit.

Outcomes achieved

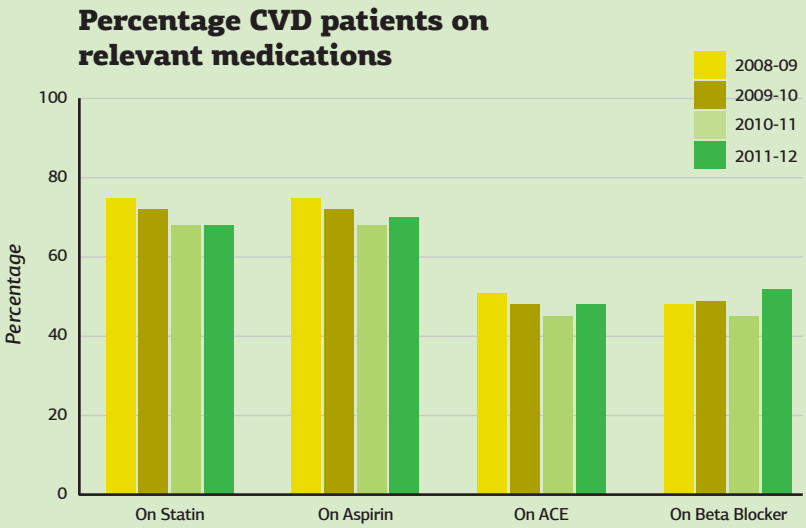
- 974 reviews were completed in the 2011-12 year compared to 900 for the 2010-11 year. According to the PHO Performance programme (PPP), the estimated number of people with cardiovascular disease for the total population is 1383.



- Myocardial infarction (MI) 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 percentages of people reviewed who are smokers and nonsmokers. Of those reviewed, 84% were not smoking:



- The following graph shows the percentage of people reviewed who were on preventive medication over the last four years:



Expenditure

CVD care is included within the $180,930 of LTC expenditure.

Care for People with Diabetes

Aim

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

Target group

All patients with diabetes.

Key activities

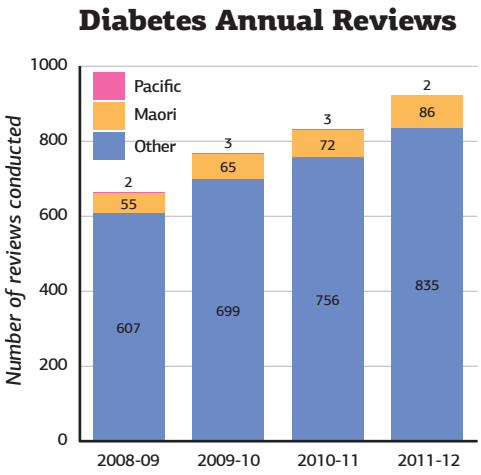
- to provide a package of care for people with diabetes that includes an annual review;
- to review both clinical management and self-management of the patient's condition;
- to organise retinal screening clinics on the West Coast for people with diabetes;
- to assist individuals living with diabetes and their family/whanau to achieve better self-management of their condition by providing opportunities for collaborative care planning and goal setting;
- 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;

Progress 2011-2012

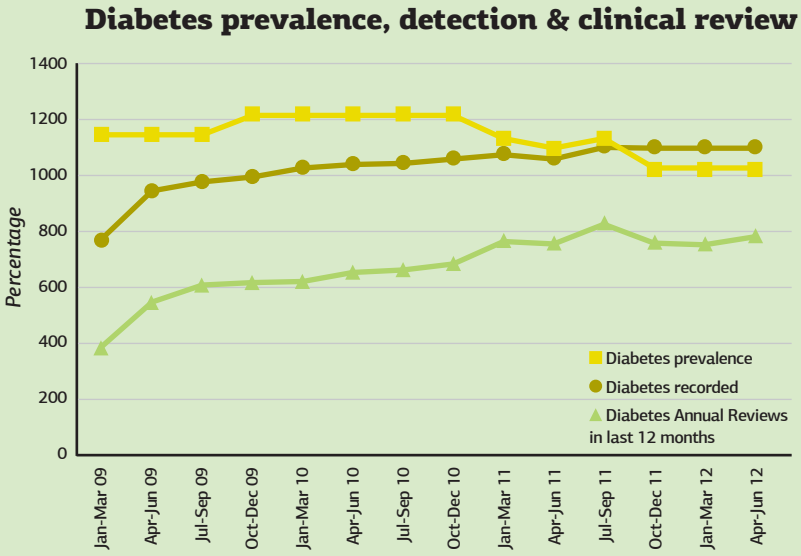
- Diabetes annual reviews are a routine aspect of planned care as part of the Long Term Conditions programme.
- Retinal screening clinics are held every quarter in the main centres and peripheral clinics in the more rural areas as needed: this year, Reefton and Franz Josef.
- Practices receive quarterly reports on annual review activity through their Quality Improvement team.
- All identified smokers are offered brief advice and support to quit.
- Renewal of the current retinal screening contract with Matthews Eyewear Eyecare Group is under negotiation.

Outcomes achieved

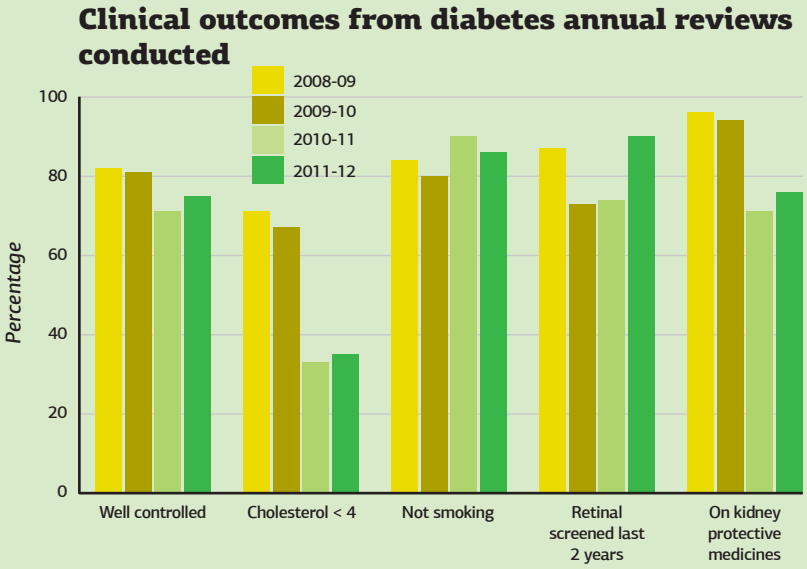
- 395 people received retinal screening this year. The target of up-to-date retinal screening for 85% of patients was exceeded, with 97% of patients being screened within the last two years.
- 923 diabetic reviews were completed this year (9% of which were for Maori).
- 923 reviews represent 84% of those who have been diagnosed with diabetes (cf. the national goal of 90%).



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 three and a half years:



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



Diabetes Self-Management Education Courses

Living and coping with Type 2 diabetes can be difficult. Involving the patient in decisions about their care has been shown to improve the health of people with a long term condition like diabetes. By becoming an educated and motivated patient, together with advice from a healthcare team, people with diabetes can lead a full and active life.

'Living Well with Type 2 Diabetes' is a course delivered by the PHO over a four week period. This course is 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 18 people attending overall.

Expenditure

Diabetes care is included within the $180,930 of LTC expenditure. An additional $47,671 was spent on retinal screening.

Care of People with Chronic Respiratory Disease: COPD

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.

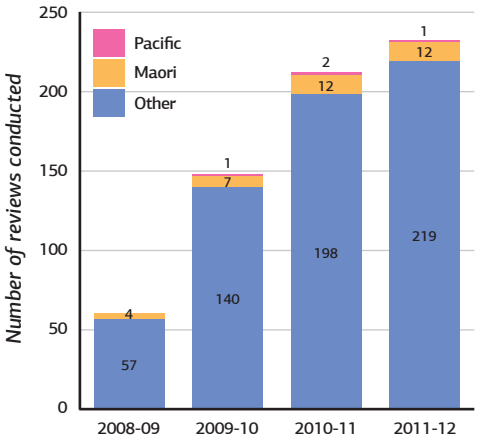
Progress 2011-2012

- COPD annual reviews are a routine aspect of planned care as part of the long term conditions programme.
- All practices are carrying out COPD reviews.
- Practice Quality Improvement teams receive quarterly reports on annual review activity.
- All identified smokers are offered brief advice and support to quit.
- Regular spirometry training is available for practice nurses.

Outcomes achieved

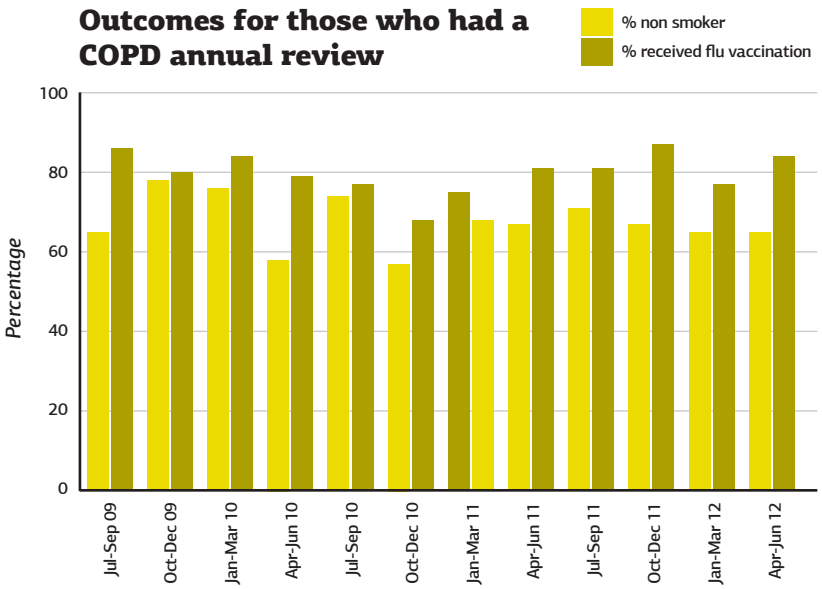
- 232 annual reviews were completed in the year.
- 5% of reviews conducted were for Maori. Maori make up 5.2% of the enrolled population aged 45+ years, which is the prime age group of people expected in the long term conditions programme.

COPD Annual Reviews

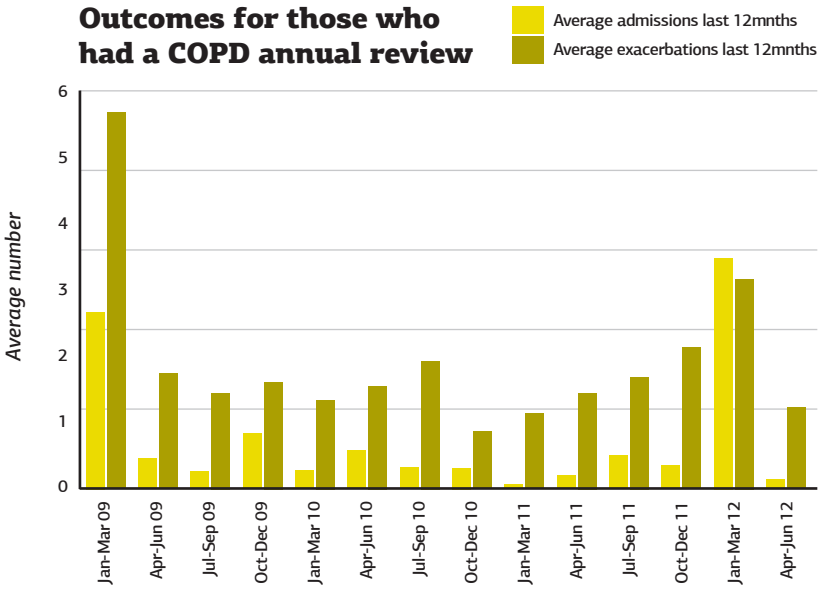


- Of those reviewed, 79% had a flu vaccination recall and 84% have been given a COPD management plan.
- The following graph shows the percentage of people not smoking,

and the percentage who have had their flu vaccination recall at the time of their annual review:



- The average COPD admission rate per patient was 1.1 per year compared with 0.22 last year.
- The average COPD exacerbation was 2 per patient this year compared with 1.3 last year.
- The following graph shows the admission rates and exacerbations by quarter:



Expenditure

COPD care is included within $180,930 of LTC expenditure.

SMOKEFREE WEST COAST

Smoking Cessation

Aim

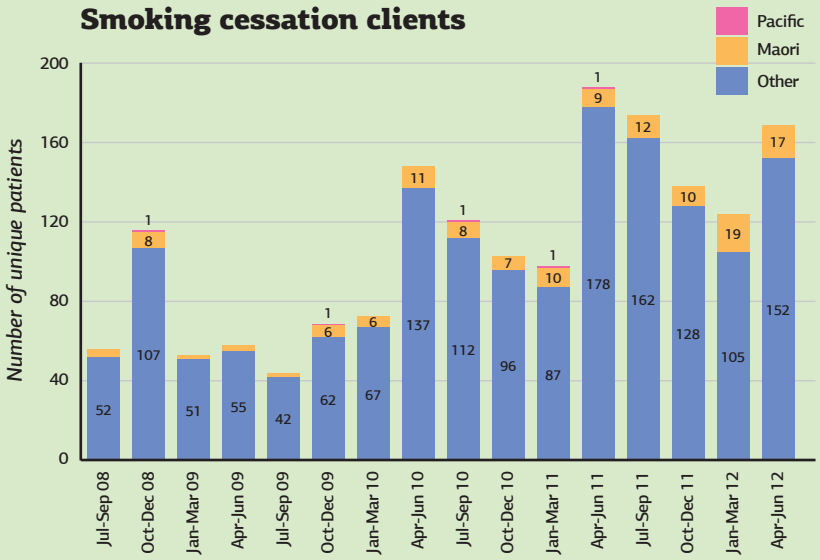
To reduce tobacco smoking through increased availability and choice of smoking cessation services in the community.

Target group

All smokers on the West Coast, in particular high need groups.

Key activities

- The 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.
- Programme participants are phoned at 3-4 months post quit date to ascertain outcome and number of contacts with the Coast Quit provider.
- Feedback on Coast Quit programme results has been provided to all practices.



Progress 2011-2012

- This year sees a new record in the PHO's Coast Quit smoking cessation programme, with enrolments far exceeding the funded 250 places.
- 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.
- Pharmacotherapy options continue to extend beyond just NRT, incorporating the full range of currently available treatments.

Outcomes achieved

- 605 enrolments in the programme; 93% of enrolments were with a practice or rural clinic, and 7% with a community pharmacy.
- Of the 605 enrolments, 58 (9.6%) were Maori.
- The quit rate for the latest 12 month data set (549 patients) is 25.1%, as recorded at 3-4 months post quit date. This is slightly ahead of the result for the previous 12 months, and is a favourable result for this type of programme.

Funding

Revenue received for smoking cessation was $25,000. Expenditure was $50,385 to meet demand. The PHO contributed the additional $25,385 from its reserved funds.

Smokefree Service Co-ordination

The West Coast Smokefree Services Co-ordinator position commenced with the PHO in October 2011.

Aim

To reduce the prevalence of smoking on the West Coast by supporting health providers in all settings, along with other groups or agencies in the community, to promote 'smokefree' and to increase the uptake of effective smoking cessation interventions.

Target group

All potential beneficiaries of a smokefree West Coast.

Key activities

- co-ordination of planning, monitoring, and reporting activities with the West Coast DHB HEHA and Smokefree Service Development Manager;
- monitoring and promoting the secondary care tobacco health target: 95% of patients who smoke and are seen by a health practitioner in public hospitals are given brief advice and offered support to quit smoking;
- involvement in other aspects of the West Coast DHB smokefree policy;
- monitoring and promoting the primary care tobacco health target: 90% of patients who smoke and are seen by a health practitioner in primary care are given brief advice and offered support to quit smoking;
- networking and collaboration with other smoking cessation services;
- organising training opportunities for all smoking cessation providers;
- working with the West Coast Tobacco Free Coalition to achieve the national goal of Smokefree Aotearoa-New Zealand 2025.

Progress and Outcomes November-June

Primary:

- Recording of a patient's smoking status is routine at all practices and rural clinics.
- All practices are working towards the Ministry of Health primary care tobacco health target. 'Brief advice to stop smoking' has been recorded for 32% of identified smokers.
- Practices received on-going support with MedTech coding for the PHO Performance Programme smoking indicators.
- ABC (Ask smoking status/Brief advice re quitting/Cessation support) presentations were delivered to a number of outpatient and community-based health services, as well as presentations to the practices on smoking cessation and the primary health target.

Secondary:

- Regular liaison with ward champions and clinical managers, and ABC presentations to hospital-based services, contributed towards achievement of the secondary care tobacco health target.
- Results for the secondary care tobacco health target have ranged between 73% and 92% over the period October to June.
- Attendance at DHB mandatory smokefree training was promoted.

Community:

- Monthly meetings were attended with the West Coast Tobacco Free Coalition, and smokefree environment initiatives were supported. The PHO was involved with a variety of health promotion activities for Smokefree May, and other events such as Relay for Life and Agfest.
- The PHO delivered a submission to a Parliamentary Select Committee on tobacco excise increases.
- ABC presentations were delivered to a number of community-based social service agencies.

Training provision:

- Cessation Practitioner Training, Stages 1 and 2, in Westport, 11 attended, and in Greymouth, 17 attended. Stage 3 Cessation Practitioner Training, 8 attended.
- Two sessions of the STEPS 'Train the Trainers' training, 14 attended.
- Introduction to Motivational Interviewing, 18 attended.

HEALTH NAVIGATOR SERVICE

Aim

To assist high need patients with Long Term Conditions (LTCs), including cancer, to access 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.

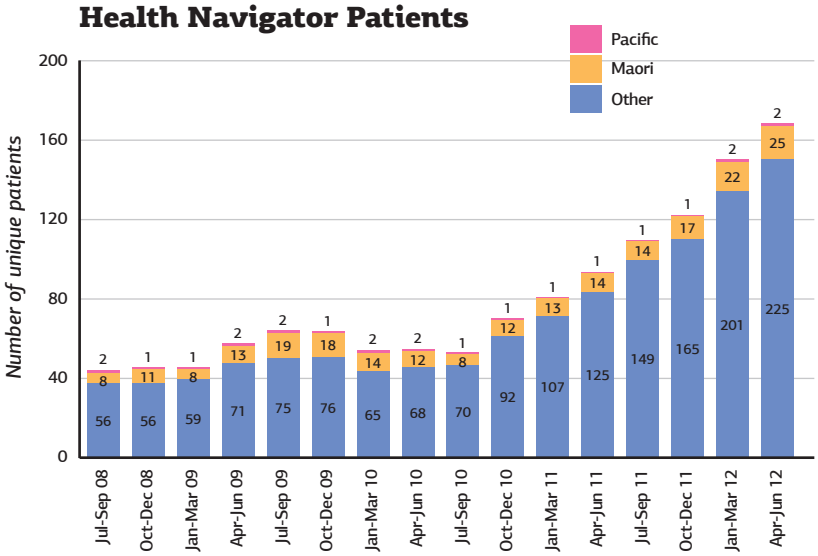
Key activities

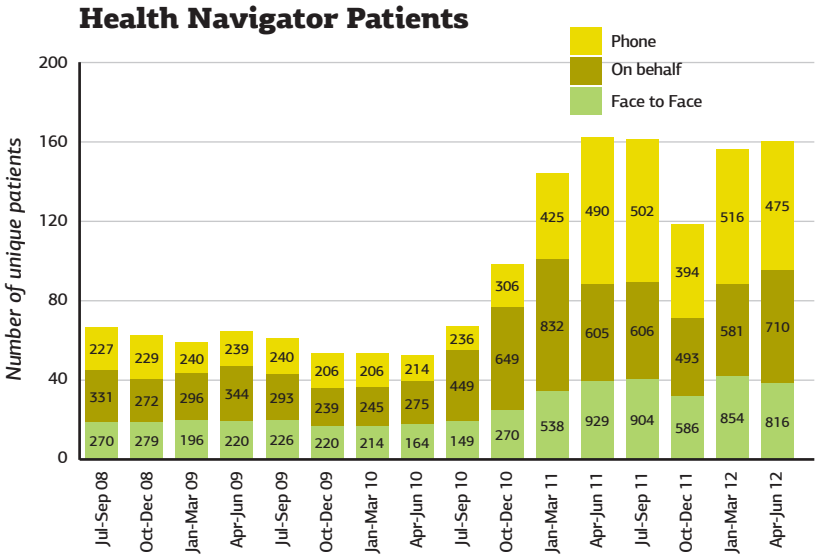
- to provide additional support for LTC patients and their whanau with complex social needs;
- to improve access to health care for these patients;
- to support the medical centres in caring for these patients;
- to improve access to social support services for these patients;
- to improve health outcomes;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

Progress 2011-2012

The Health Navigator service has continued to strengthen and add value to the journey of those under its care as they navigate a system that, at times, is quite foreign to them. The Health Navigators continue to help with identifying service gaps, increasing patient satisfaction and strengthening community and hospital connections. The service contributes to better health outcomes.

Outcome achieved





HEALTH CHECKS FOR CLIENTS OF THE CORRECTIONS DEPARTMENT

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 need clients to free general practice care and prescriptions.

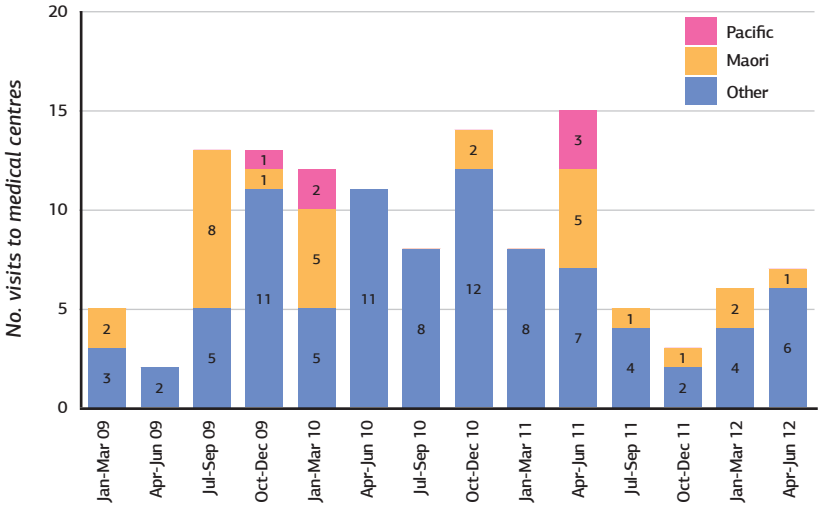
Progress 2011-2012

- Utilisation of this programme was half of what it was last year.
- This programme continues to benefit a very small number of high need individuals.

Outcomes achieved

- 24% were Maori, 76% Other ethnicities;
- 21 contacts were made at medical centres this year, as shown in the following graph.

Corrections Department Clients



Expenditure

$645

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 who require contraception and sexual health services (under 25 years for Franz Josef and Fox Glacier only).

Key activities

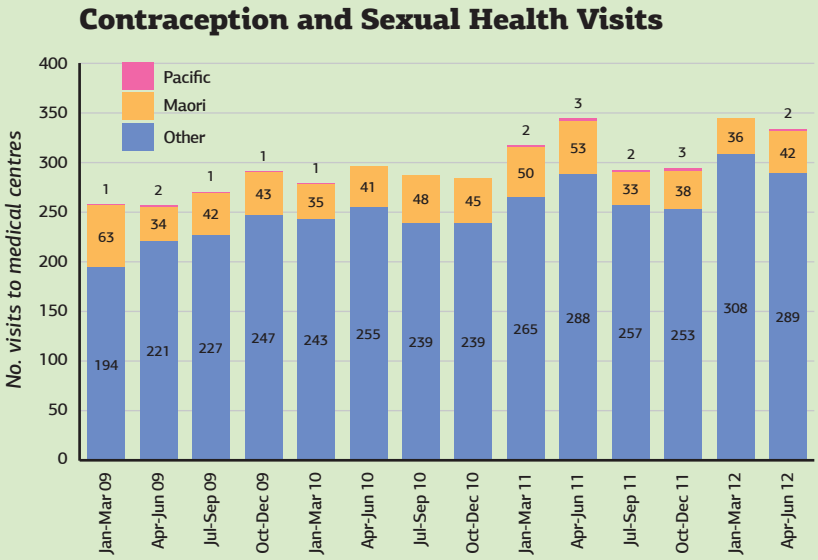
- to remove financial and social barriers to accessing contraception and primary sexual health services for young people, particularly those at risk of ill health, injury and unwanted pregnancy;
- to ensure a wide range of access points to this service via provision at all practices and rural health 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 2011-2012

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

Outcomes achieved

- The number of individual visits to practices increased this year by 31; 12% of visits were made by young Maori.
- The graph below shows the trend of increasing visits to practices over time:



Expenditure

$24,498

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.

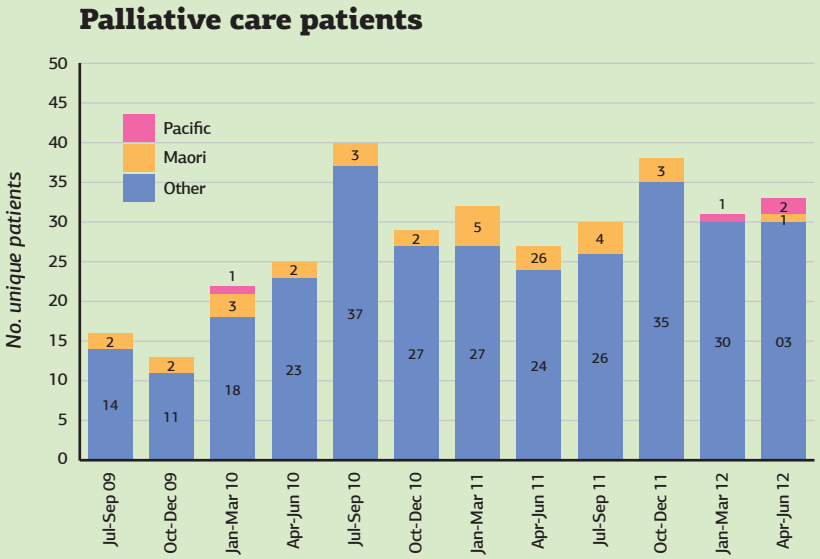
Progress 2011-2012

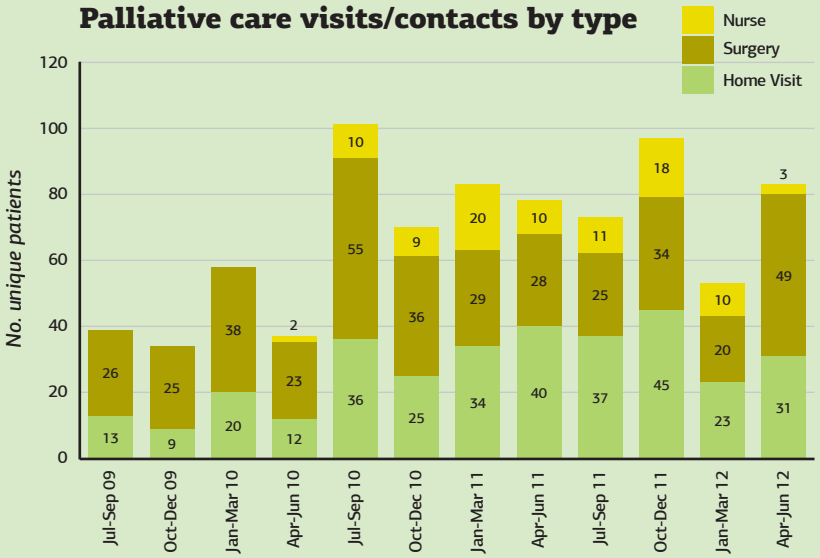
- This programme continues to cover the costs of visits to the general practice, home visits, virtual visits made on behalf of patients by palliative nurse specialists, and some part-charges for medication used in a palliative setting for enrolled palliative care patients.

Expenditure

$14,074

Outcome achieved





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

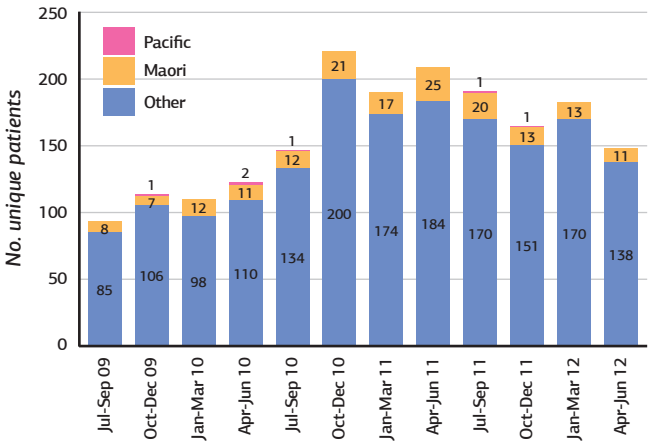
- triaging of requests from GPTs and, in the case of young people, school counsellors and relevant social agencies, with assessments completed as appropriate;
- provision of up to 6 fully-funded Brief Intervention Counselling (BIC) sessions (or up to ten sessions with young people where other relevant people involved) 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 2011-2012

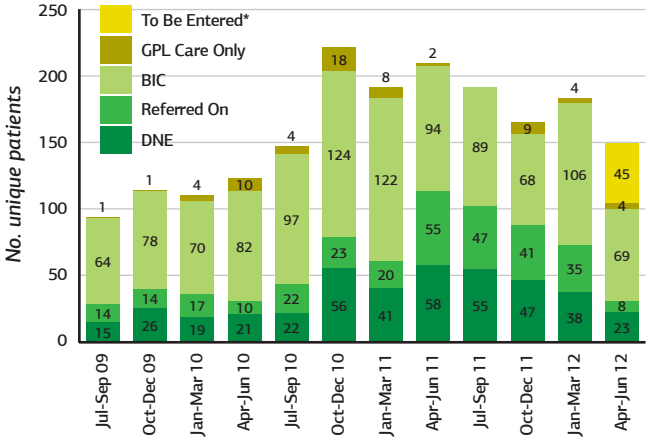
- There were 688 requests for assistance from the primary counselling service this year, down from the 768 requests made in the previous year (which included Pike River Mine explosion and Canterbury earthquakes) but well above the 439 of the 2009-2010 year.
- The number of people receiving counselling followed a similar trend with 292 (246 adults and 46 youth) in 2009-10, 431 (356 adults and 75 youth) in 2010-11, and 315 (265 adults and 50 youth) in the current year.
- The annual roadshow held in the practices over December and January was entitled 'Cheese and Crackers'. It was a good opportunity to give and receive updates about the programme and to inform practice staff about 'Beating the Blues', an e-therapy programme now funded by Ministry of Health.
- Practices were also asked to halve their use of Extended Consultations for mental health issues, as claims received totalled over twice the budgeted amount. This year, 754 claims were made, whereas the budget covers 368 consults. Additional revenue to fund the higher level of usage had been sought but not obtained.
- A new staff member, a psychologist, was appointed to work in primary mental health in Buller from January, while in Westland a student counsellor undertook supervised counselling with selected patients of Westland Medical Centre from December.
- Wherever possible, people are seen in their medical centres, but with space at a premium this is not always possible. A room the PHO has rented in Buller for primary mental health use has proved beneficial. Westland Medical Centre personnel are very helpful in accommodating the primary mental health team.
- The team's GP Liaison nurse has successfully instituted weekly meetings with all Greymouth practices as well as the Community Mental Health teams.
- All team members receive supervision and training and have forged links with relevant NGOs and other social agencies.

Outcome achieved

MH requests for assessment

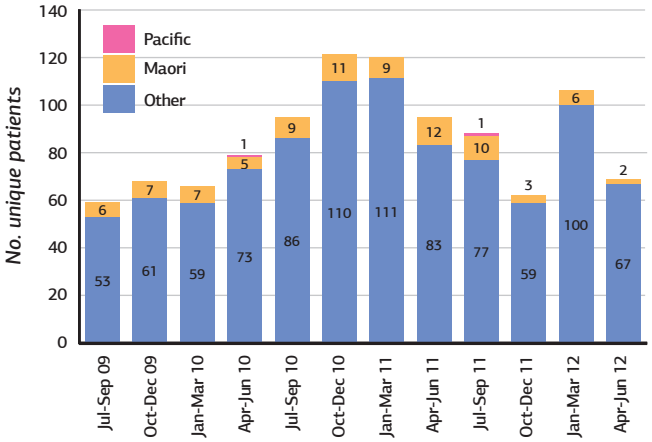


Treatment pathway upon referral

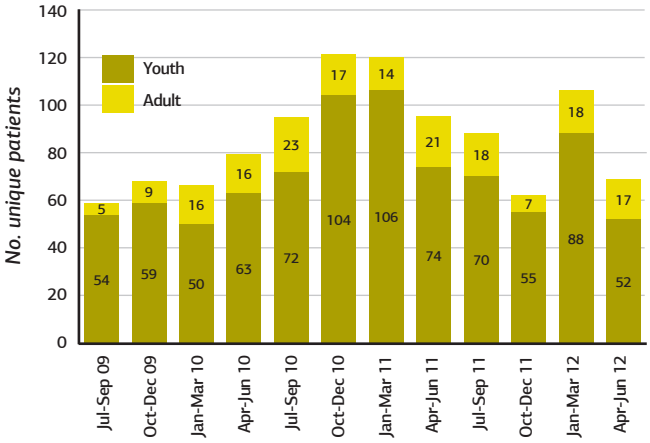


** requests received but pathways being determined.*

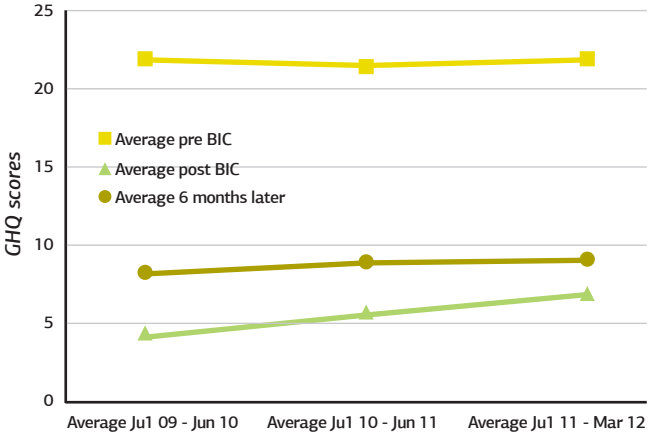
Patients brief intervention counselling (BIC)



Patients - brief intervention counselling (BIC)



Patient Outcomes (change in GHQ scores)



The instrument used to obtain evaluation measures is the General Health Questionnaire (GHQ12). The scoring gives a total of 0-36, the higher the number, the greater the psychological distress. The GHQ is completed three 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 these data, indicating that the beneficial changes experienced by people undergoing BIC are sustainable over time.

Expenditure

$493,582

QUALITY IMPROVEMENT, PROFESSIONAL DEVELOPMENT, WORKFORCE AND RURAL SUPPORT

PHO Performance Programme

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 practice's efforts for the year. This plan is submitted to the Clinical Governance Committee annually. This process fulfils the RNZCGP's Cornerstone objective as per Indicator 10, Section 1.
- 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.
- The programme acts as a means to focus activities that support other programmes, e.g. cervical and breast screening, childhood and influenza immunisations and the primary care tobacco health target.

Outcome achieved

- Those indicators that are linked to the Long Term Conditions (LTC) 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, and influenza vaccinations, with the PHO exceeding the national rate in some of these indicators.
- For breast screening coverage (high need population) the trend continues to improve and remains higher than the rate achieved nationally.
- Cervical screening rates for both total population and the high need population continue to improve and are now above the national rate and just short of the national target.
- Screening for 5 year cardiovascular risk has steadily increased across total and high need population groups – both exceeding the national rate.
- There has been steady improvement in recording of smoking status, which now stands at 74% of the West Coast population.

- A quality improvement study day was held in March. The programme included a review of LTC data, primary care and health of the older person, and a review of Quality Improvement and Maori Health plans. 24 representatives from all three general practice professional groupings attended.

Expenditure

The PHO spent $1,128,866 on its various quality improvement activities and professional development support. Of this amount, $54,451 came from the PHO's reserved funds.

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.
- Regular feedback about prescribing errors is provided by community pharmacy to practices, backed-up with quarterly visits to practices by a community pharmacist.

Outcome achieved

Local study days:

- 48 participants attended the Primary Health Day;
- 24 participants attended a QI Team study day;
- 21 participants attended a Cardiac Society 'road show';
- Introduction to Contraception study days were held in Westport (7 attendees) and Greymouth (12 attendees);
- Smoking Cessation training: 1 Motivational Interviewing training day was held this year with 18 attendees; 2 Cessation Practitioner 2-day courses and 1 Advanced course were held this year with 36 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 19 sessions were presented, with a total of 110 GP attendances, 80 nurse attendances and 12 other attendances. Topics included 'dread of being on call', 'beating the blues', palliative care, rheumatology, 'stitching things up', somatisation, orthopaedics, diabetes, atrial fibrillation, endocrinology, the coroner's role, prescribing errors, dementia, neurology, and rest home communication.

Cornerstone practice accreditation:

- to date, six practices/rural clinics are accredited out of 7, including one re-accreditation this year.
- Another practice has been assessed and is in active preparation for accreditation next year.

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 rostering and rural bonus payments to eligible service providers (all those outside of Greymouth) contracted to the PHO;
- two GP registrar scholarships available, to attract young GPs to the West Coast;
- ancillary support to practices (in extraordinary situations) for continuation of medical services;
- the after-hours plan is now in operation;
- team building and individual mentoring sessions for the 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 continues to support practice teams after hours;
- standing orders are routinely used in some practices, with training continuing for others;
- 1 GP registrar scholarship awarded;
- PHO Medical Director has facilitated a number of meetings regarding the recruitment and retention strategy and its implementation;
- a Practice Manager/Consultant was hired to assist a practice with management processes and practice development;
- a new initiative for General Practitioners and Rural Nurse Specialists was established in August with a 'Punakaiki Weekend Away'. The weekend conference was attended by 13 GPs and 8 Rural Nurse Specialists. The aim was to provide participants with educational and skills-based interdisciplinary learning opportunities as well as chances to meet and network with other rural colleagues. This was part of a strategy to encourage and foster the retention of valuable rural staff.

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 and Outcomes Achieved

People are healthier:

- 2169 patients were enrolled in the Long Term Conditions (LTC) management programme and 1253 patients received support through Health Navigators.
- 1874 patients received a cardiovascular annual review, an increase of 23%, and 1754 patients received a diabetes annual review, an increase of 61%.
- 857 referrals were made to Green Prescription and 2405 referrals were made to West Coast smoking cessation services to help people make small changes that make a big difference to their health and wellbeing.
- Avoidable hospital admissions rates stayed well below the national average.

People wait less:

- 28864 calls to general practices were answered by the nurse-led after-hours phone triage service, providing callers with immediate health advice and guidelines.
- Introduction of the Nurse Practitioner role in General Practice to improve access to the primary healthcare team.

Services are delivered closer to home:

- Carelink and community nursing moved to support packages with a restorative focus in the community to help West Coasters to stay well and independent in their homes.
- Implementation of Mobile Dental Services in schools contributed to an increase in the percentage of 5 year-olds who are caries-free from 52% to 61%.
- The Complex Clinical Care Network (CCCN) was launched to ensure the most suitable health professional is readily available to provide care where and when it is needed through integration between secondary, aged residential and primary care.

Services are integrated:

- Manage My Health began providing a secure system for sharing key patients between health professionals, enabling faster, safer treatment for patients.
- Buller IFHC initiated access across the local health system via MedTech to ensure timely sharing of accurate information among members of the health care team (including primary, community and appropriate hospital clinical staff), enabling a faster and safer package of care to be delivered to the patient.
- Multidisciplinary meetings between general practice nurses and doctors and community and district nurses were established in all practices, ensuring better information flow and therefore a better patient experience.
- The CDHB's 519 pathways and clinical resources were made available to GPs and health professionals on the West Coast through the Health Pathways website. 196 of these pathways or parts of the pathways have so far been localized for the West Coast to help provide consistent, integrated care of patients.

Expenditure

The PHO spent $196,553 on implementing the BSMC plan, of which $181,359 came from the PHO's funds.

A Selection of the Groups and Agencies we worked with During the Year:

Navigator Service

- Access Home Health
- Arthritis New Zealand
- Banks (Kiwibank, BNZ, ANZ, National, Westpac, Credit Union)
- Barristers/Solicitors
- Budget Advice
- DHB Community Service (Meals on Wheels, Social workers)
- CYFS
- Dentists
- Funeral Directors (Westland, Anisy's, Thompson's)
- Hokitika District Multi-Disciplinary Team
- House of Hearing
- Justice Department
- Literacy Westland
- LTSA
- Maori Mental Health
- Maori Women's Welfare League (Kotuku, Rata,Te Aiorangi, Kawatiri)
- Ministry of Health (National Travel/Carer Support)
- New Zealand Police
- Occupational Therapy (DHB)
- Palliative Care Nurse Specialist
- Physiotherapy
- Plunket
- Public Trust
- Relationship Services
- Salvation Army
- SPCA
- Stroke Foundation
- St John (Medical alarms/Ambulance)
- St Vincent De Paul
- Supporting Families
- Westport Homebuilders
- Women's Refuge
- Work and Income
- Workbridge

Service Sub Contractor

- Cathy Edwards (Life Coach)
- Optometrists (Coast Optometrist, Van Paassen, Matthews Eyewear Eyecare)
- Buller's Solid Energy Centre

Community Network

- Active West Coast
- Aquatic Centre Greymouth
- BABES in arms
- BIG (Breastfeeding Interest Group)
- Buller West Coast Home Hospice Trust
- Buller Women's Health Fund
- Cancer Society
- Canterbury West Coast Sports Trust
- Cardiac Clubs
- Care Network Group
- Carelink MDT
- Child & Family Support Service
- Community and Public Health
- Disability Resource Centre
- District Councils (Grey, Buller, Westland)
- Family Start
- Focus Trust
- Grey District Library
- Healthy West Coast Governance Group
- Heart Respiratory Team (HRT)
- Immunisation Advisory Group (IAG)
- Kids n Coffee group
- Local Cancer Network
- Local Diabetes Team
- Local media
- Mayors (Buller, Grey, Westland)
- Mum4Mum Peer Supporters
- OSH nurses and staff (Solid Energy, Holcim Cement, Westland Milk Products)
- Parents Centre
- Potikohua Trust,
- Presbyterian Support
- Rata Te Awhina
- Richmond Trust
- Rusty's Facebook page friends
- Southern Cancer Network Steering Group
- Sports West Coast
- Tai Chi
- The Hub, Cobden
- Under 5's Network
- Well Women's Centre
- West Coast Development Trust
- West Coast Smoke Free Coalition

Schools/Youth/Education

- Buller High School
- Buller REAP
- CAMHS
- Distance Learning/Evening Classes
- Greymouth High School
- Karamea Area School
- Karoro Learning
- Reefton Area School
- School Counsellors
- Te Tai o Poutini Polytechnic
- Te Wananga o Aotearoa
- Westland High School
- Youth Network
- Youth Workers Collective

Medical/Pharmacies

- Buller Health Medical Centre
- Central Booking Unit (DHB)
- Cervical Smears Coordinator
- Coastbirth Midwives
- Community Mental Health teams (Buller, Greymouth and Westland)
- Community Pharmacies
- Dietician (DHB)
- Greymouth Community Mental Health MDT
- Greymouth Medical Centre
- High Street Medical Centre
- Karamea Health Clinic
- Maternity Wards (Buller, Greymouth)
- National Cervical Screening Coordinator (DHB)
- Nurse Specialists DHB (Respiratory, Cardiac, Urology, Diabetes, Oncology/Cancer)
- Outreach Immunisation Co-ordinator
- Podiatrist (DHB)
- Reefton Medical Centre
- Rural Academic General Practice
- South Westland Area Practices and Rural Clinics
- TACT Psychiatric Emergency Team
- Westland Medical Centre

Coasters Connecting with Primary Health Care

Maura Atkinson – I was 90.2 kg and health wise I was feeling terrible, I couldn't even walk to the mailbox without puffing. I was having problems with my heart and just didn't know where to start and then I was told about Green Prescription. What a difference it has made to me. I have lost 20 kg. I'm now fit and healthy enough to go to the mailbox without having a heart attack. I was seeing a heart specialist and because of the weight loss he said I have a better chance of living a longer life. For me, losing weight and maintaining a healthy lifestyle is crucial. I have not only lost weight but my attitude has also changed. I feel more positive and I'm spending more time doing the things I love. My husband has been there all the way encouraging me to achieve my goals. I have a better outlook and I'm looking forward to living a better and longer life.

Ross Jellyman – My son Tom and I were felling trees for firewood and removing stumps when I got light headed and very dizzy. Thinking little of it I sat down for a minute and took a rest. Tom had just completed a first aid course and concluded that I'd had an angina attack and if I didn't get in the car he was calling an ambulance, so to the hospital we went. The only pain I felt was in the centre of my chest which disappeared soon after. An ECG and blood tests showed that I had indeed had a heart attack. An angiogram in CHCH showed I had several blockages and I was in need of urgent quintuple bypass surgery. Since the operation I feel a lot healthier and can manage activities far better. I often wonder what would have happened had Tom not been there. I probably would have carried on not giving it another thought. Anybody who has something unexplained happen, however insignificant you may think it is; get it checked.

Wendy Tomasi - June 2010 I arrived home from work and went straight to bed as I was extremely tired. That was the start of the worst case of flu I have ever had. I rarely get sick. After three days of agony I saw a doctor. It took all my effort to get myself dressed and to the doctor. The doctor said I would need to have another week off work. My husband got a flu jab there and then, (there was no way he was getting what I had) and thankfully he didn't. The next week I spent in bed coughing, sweating, aching; only getting up to shower (with help). My fever was horrendous and I needed to keep up with medication regularly for a fortnight. When I manage to return to work I was weak and was unable to work a full day for another two weeks. I was tired and worn out most days. It was about two months before I felt normal again. I hope that flu is the only one I ever get. I will never go without the flu jab in future.

Fiona Thomas - I had Post Natal Depression (PND) after the birth of my first baby. I had difficulty bonding with my baby because of the PND and thought that having him had been a terrible mistake. I sought help from my lactation consultant (LC) who referred me onto secondary care. I am ever so thankful to my LC who helped me through this difficult time. I am now utterly in love with my son. Getting help with my PND was essential for me and my family's wellbeing. PND or any form of depression is common and you can get help. It's nothing to be ashamed of.

FINANCIAL STATEMENTS

West Coast
Te Tai o Poutini
Primary Health

For the year ended 30 June 2012

INDEX

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

DIRECTORY

AS AT 30 JUNE 2012

PRINCIPAL BUSINESS:	Primary Health Organisation
ADDRESS:	PO Box 544 163 Mackay Street GREYMOUTH
TRUSTEES:	Trustees at 30 June 2012 John Boyes Anna Dyzel Maureen Pugh Tim Rochford Rosalie Sampson Richard Wallace Tony Coll Francois Tumahai Toni Caldwell
INDEPENDENT CHAIRPERSON:	John Ayling
AUDITORS:	WHK Otago DUNEDIN
SOLICITORS:	Hannan & Seddon GREYMOUTH
BANK:	Westpac Bank

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2012

	2012	Consolidated 2011 $	Parent 2011 $
INCOME			
Revenue	8,208,994	8,179,204	8,104,688
Interest Received	47,932	57,748	57,748
Sundry Income	32,670	23,274	23,274
Depreciation Recovered	-	2,624	2,624
TOTAL OPERATING INCOME	8,289,596	8,262,850	8,188,334
OPERATING EXPENSES			
Donation	-	7,299	250
Audit Fee	11,856	11,419	11,419
Bad Debts	-	5,758	5,758
Bank Fees	708	2,289	902
Contract Payments	6,607,156	6,659,001	6,659,001
Directors Fees	-	6,700	-
Insurance	7,058	6,479	6,001
Interest Expense	-	6,762	-
Leases	140,102	126,009	118,678
Loss on Disposal of Assets	-	87,461	17,821
Other Expenses	310,768	367,080	302,732
Telecommunications	36,039	51,515	49,022
Salaries & Wages	1,038,602	974,591	915,226
Trustee Meeting Fees	106,980	70,184	70,184
Trustee Reimbursements	22,197	19,639	19,639
Depreciation	63,031	72,552	72,552
Impairment Adjustment	-	-	176,279
	8,344,497	8,474,738	8,425,464
NET SURPLUS/(DEFICIT) FOR THE YEAR BEFORE TAX	(54,901)	(211,888)	(237,130)
Tax Expense	-	10,800	-
SURPLUS/DEFICIT FOR YEAR AFTER TAX	(54,901)	(222,688)	(237,130)

WEST COST PRIMARY HEALTH ORGANISATION TRUST

STATEMENT OF MOVEMENTS IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2012

	2012 $	Consolidated 2011 $	Parent 2011 $
Net Surplus/(Deficit) For The Year	(54,901)	(222,688)	(237,130)
TOTAL RECOGNISED REVENUE AND EXPENSES	(54,901)	(222,688)	(237,130)
Equity at Beginning of Year	603,294	815,182	840,424
EQUITY AT THE END OF THE YEAR	548,393	592,494	603,294

WHK
FOR IDENTIFICATION PURPOSES ONLY

M.R.

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2012

	Note	2012 $	Group 2011 $	Parent 2011 $
EQUITY	4	**548,393**	**592,494**	**603,294**
Represented By:				
CURRENT ASSETS				
Westpac Bank		21,988	53,272	53,272
Westpac Bank Saver		954,315	1,259,933	1,259,933
Accounts Receivable		579,426	169,563	174,585
Petty Cash		38	115	115
Prepayments		4,745	4,942	4,942
GST Refundable		23,229	9,098	4,076
TOTAL CURRENT ASSETS		1,583,741	1,496,923	1,496,923
NON-CURRENT ASSETS				
Property, Plant & Equipment	6	151,927	181,584	181,584
TOTAL NON-CURRENT ASSETS		151,927	181,584	181,584
TOTAL ASSETS		**1,735,668**	**1,678,507**	**1,678,507**
CURRENT LIABILITIES				
Trade creditors		706,199	305,890	305,890
Reserved Funding		417,120	727,751	727,751
Employee Entitlements		49,039	41,572	41,572
Provision for Taxes		-	10,800	-
Revenue in Advance		14,917	-	-
TOTAL CURRENT LIABILITIES		**1,187,275**	**1,086,013**	**1,075,213**
NET ASSETS		**548,393**	**592,494**	**603,294**

For and on behalf of the Trustees

Trustee

Date 18-10-12

Trustee

Date 18-10-12

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WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2012

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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 Trust 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.

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.

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FOR IDENTIFICATION PURPOSES ONLY

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2012

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

COMPARATIVE FIGURES

The PHO had a 100% interest in Greymouth Family Health Centre Ltd. This company had a 30 June year end, was incorporated on 13 May 2009 and ceased trading on 10 September 2010. The company was wound up on 27 January 2012. Accordingly consolidated balances are not relevant as no subsidiary activity occurred.

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 (2011: NIL) as at balance date.

There were no contingent liabilities at the balance date (2011: NIL).

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2012

4 TRUST EQUITY

	Group 2012 $	Group 2011 $	Parent 2011 $
Retained Earnings			
Retained Earnings at Start of Year	603,294	65,182	90,424
Net Deficit For The Year	(54,901)	(222,688)	(237,130)
Transfer from/to BSMC Reserve	-	750,000	750,000
Retained Earnings at End of Year	548,393	592,494	603,294
BSMC Reserve			
Reserve at Start of Year	-	750,000	750,000
Transfer from/to Retained Earnings	-	(750,000)	(750,000)
Reserve at End of Year	-	-	-
TOTAL TRUST EQUITY	**548,393**	**592,494**	**603,294**

The BSMC Reserve was created in the 2010 financial year to recognise 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:

	2012	2011
Current Portion	137,716	51,931
Non-Current Portion	61,879	65,038
	199,595	116,969

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2012

6 PROPERTY, PLANT & EQUIPMENT

2012	Cost	Depn	Accum Depn	2012 Bk Value
Building Improvements	111,080	7,176	64,662	46,418
Motor Vehicles	33,043	8,178	13,961	19,082
IT & Plant	256,256	47,677	169,829	86,427
	400,379	63,031	248,452	151,927

Parent - 2011	Cost	Depn	Accum Depn	2011 Bk Value
Building Improvements	86,563	7,818	50,919	35,644
Motor Vehicles	33,043	6,925	5,783	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	7,818	50,919	35,644
Motor Vehicles	33,043	6,925	5,783	27,260
IT & Plant	247,400	57,809	128,720	118,680
	367,006	72,552	185,422	181,584

WHK

INDEPENDENT AUDITOR'S REPORT

To the Trustees of the West Coast Primary Health Organisation Trust

Report on the Financial Statements

We have audited the financial statements of the West Coast Primary Health Organisation Trust on pages 40 to 47, which comprise the Statement of Financial Position as at 30 June 2012, 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 Financial Statements

The Trustees are responsible for the preparation and fair presentation of these 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 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 financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the 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 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 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.

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 as at 30 June 2012 and its financial performance for the year then ended, in accordance with generally accepted accounting practice in New Zealand.

WHK OTAGO

18 October 2012

Dunedin
CHARTERED ACCOUNTANTS

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West Coast
Te Tai o Poutini
Primary Health

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