Annual Report

07 08

WEST COAST
Te Tai o Poutini
Primary Health Organisation

West Coast PHO

Strategies and priorities

The purpose of the PHO is to promote and enable better health for the population on the West Coast and actively work to reduce health inequalities amongst at-risk and disadvantaged groups.

The PHO will strengthen and grow its organisational functions as funder, service provider, and service coordinator within primary care, as a means to achieving this end and in alignment with the Government's Primary Health Care Strategy (PHCS).

Strategic objectives are to:

- Work with local communities and enrolled populations
- Identify and remove health inequalities
- Offer access to comprehensive services to improve, maintain, and restore people's health
- Co-ordinate care across service areas
- Develop the primary care workforce
- Continuously improve quality using good information and evidence

We Will Focus On:

- Improving the management of patients with chronic care conditions
- Closing gaps of inequality for Maori
- Improving access to mental health services, including young people
- Improving the quality of life, eg Cancer support
- Improving immunisation rates
- Enhancing disease prevention programmes
- Improving the coordination of services both within and across services

By using key mechanisms and enablers such as:

- Better engagement with the community, families/whanau and individuals
- Improved collaboration at strategic and planning levels with the DHB and Community & Public Health
- Greater integration with other organisations and NGOs
- Supporting GP practice teams
- Supporting individuals and whanau
- Enhanced health promotion
- Adoption of efficient business/service models

Contents

1.

Trustees Report

Trustees take pleasure in presenting the Annual Report and Financial Statements for the year ended 30th June 2008.

The West Coast Primary Health Organisation [PHO] is a not-for-profit charitable Trust which is funded, through a variety of contracts with the West Coast District Health Board and other funding bodies such as ACC and the Ministry of Social Development, for a range of primary health care services to the people of the West Coast who are enrolled. 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 the maintenance of good health.

Trustees represent varying community and provider interests in the decision making of the West Coast PHO.

In my report of last year I noted that the Trust had reviewed its Constitution, part of which involved the appointment of new Trustees. The new Trustees are detailed in the Directory of this report. During the year, Judy Gilmour resigned [on account of leaving the Coast] as did Ms Jo Spargo, and Elinor Stratford retired. The Trust is grateful and has acknowledged the service provided by these three former Trustees. During the term of this report we were pleased to welcome Mr Tony Coll as a new Trustee.

In March of this year Trustees in collaboration with other key partners reviewed the overall purpose of the West Coast PHO, having regard for the needs of the population and in particular those who are deemed to have poor health status. The outcome of that review was the development of a set of objectives and priorities as set out on the inside front cover of this annual report.

The Chief Executive's report highlights the significant progress and gains in a number of services consistent with our purpose as outlined above.

Our relationship with the West Coast District Health Board continues to be a mature and confident partnership.

The West Coast PHO concluded the year with a surplus of $396,000, which will be reinvested back into health services and programmes for the coming 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. In this respect the professional support, expertise and energy of the CEO and staff of the PHO together with the support from the principals of PHOcus on Health has been a significant contributing factor to the results as set out in this report.

Collectively our position is such that the PHO is able, and as supported by the 3 year strategic plan, to further develop its contribution to accessible and viable health care services to the West Coast.

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

For and on behalf of the West Coast Board of Trustees.

John Ayling
Chair

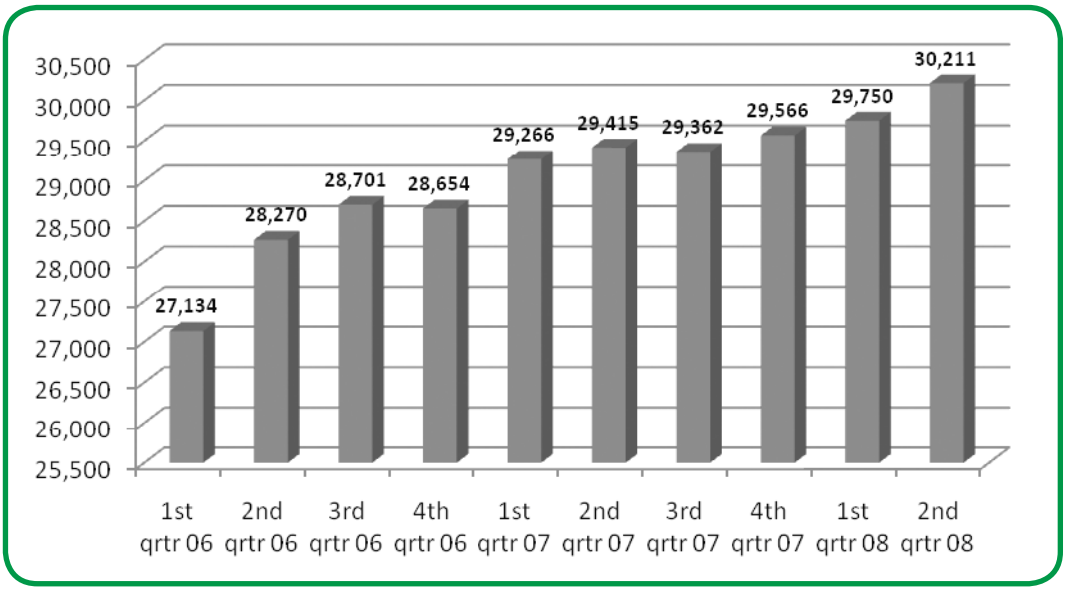
2.

CEO's MANAGEMENT REPORT

The PHO has grown significantly over the 2007-08 year with an increased number of community programmes supported by new funding streams. A CEO was appointed in August 2007 and the team has doubled in size and moved into new office premises in Mackay Street.

At the end of June 2008 the PHO enrolled population was 30,211, up from 29,415 at the beginning of July 2007, continuing the steady growth in people enjoying the health and financial benefits of being enrolled.

Enrolled Population Over Time



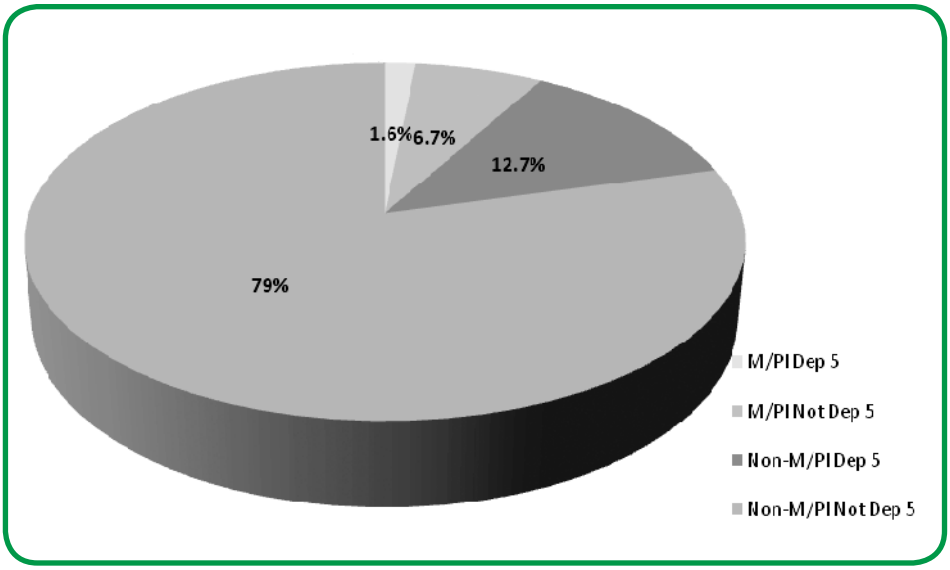
All 8 GP practices on the Coast, from Karamea to the Haast, belong to and are contracted to the PHO, and during the 2007-08 year all of these practices opted to become Very Low Cost Access practices, which means a lower medical and pharmaceutical cost to the community. The West Coast region is the only one that offers this benefit from all practices.

The following table shows what patients pay for a standard visit to the GP within normal office hours. The PHO received notification that the co-payment for adults will increase to $16 from 1 July 2008.

Under six	$0
6 to 17 yrs	$10.50
Adults	$15.50

Total practice visits coast-wide totalled 107,072, approximately 62% of these visits being to a doctor and 38% to a practice nurse. This indicates a 2 year trend of increased visits to practice nurses which means that GP practices are working with a greater team approach to health care.

Make- Up Of Enrolled Population For Quarter
April - June 2008



The PHO team increased from 7 full time positions as of 1 July 2007 to 15 full time positions as of 30 June 2008, based in Greymouth and Westport. 80% of the staff are involved in clinical activity and/or direct delivery of health programmes and services to the community.

The PHO programmes have increased in the areas of health promotion, mental health services, outreach services such as the cancer navigation and support services, community activity and support services, breastfeeding support, smoking cessation programmes, rural staff retention initiatives, initiatives to detect and prevent cardiovascular problems and diabetes, contraception, palliative care, and helping people to manage their chronic condition eg lung disease or diabetes.

Highlights of the year included the implementation of the cancer navigation and support programme where a team (with one member based in Westport) assists people with cancer and their families/whanau to navigate any difficulties in access to treatment, transport, ongoing support and rehabilitation. The team of four have assisted over 55 people Coast-wide since starting in November 2007 and have clocked up 768 hours of time assisting people with cancer, particularly in remote rural areas.

The establishment by the PHO of a Kaiawhina service in the Buller has increased the enrolment of Maori people into GP practices by 32% in the 2007-08 year. This means that children can have access to immunisations and families access to primary health services that they were previously missing out on. The Kaiawhina service in the Buller has won national attention by becoming a finalist in the Ministry of Health Quality and Innovation Awards which will be held in Wellington in November 2008.

The PHO breastfeeding support programme resulted in a greater number of workplaces becoming baby friendly and the graduation of 3 Mum4Mum programmes in Greymouth, Westport and Hokitika which means that breast feeding mothers can support other mothers with breastfeeding challenges in the community.

The PHO is delighted to have contracted out programmes around living a healthier life and managing diabetes to Rata Te Awhina and the Arthritis Society so that people in the community can take greater control of their conditions.

The PHO Clinical Governance Committee has strengthened and continues to recommend new PHO clinical and community programmes to the PHO Board for implementation. The committee did a lot of work in ensuring the new Chronic Conditions programme, the first nationally, was robust and workable and likely to be of the most benefit to the community.

The PHO ran 3 Men's Health forums Coast-wide which proved very popular. The forums were designed to attract men to come and learn about conditions which they could prevent by early detection and by changing lifestyles eg prostate cancer, cardiovascular disease, diabetes, etc. The forums were held in Reefton, Hokitika and Greymouth and were so well attended they will be run again in the 2008-09 year.

The Continuing Medical Education programme, coordinated by Dr Anna Dyzel, continues to run smoothly and included a PHO learning and celebration day for all GP practice teams and PHO staff in November 2007. This will be repeated.

Collaboration between the DHB, PHO and Community & Public Health has strengthened even more with the formation of the Health Promotion Infrastructure Group, attended by senior organisational staff, to ensure that funding is directed to optimise programmes and benefits to the community eg smoking cessation, community activity promotion, school programmes, Hui, etc by avoiding duplication of services and working together to ensure greater success.

The PHO and DHB remain in negotiations about After Hours arrangements for the people of the Coast, with an objective to establish a sustainable and equitable after hours primary health service reflecting the different needs in various locations.

The PHO held a strategic planning day in April 2008 and developed a programme to support its two main objectives: to reduce health inequalities in the community and to improve the health of the community. The PHO has retained earnings as at 30 June 2008 of $716,326. Of these funds $396,376 is tagged for spending in particular areas under the terms of the PHO contracts with its funders.

Accumulated Surpluses	$
HP Coordinator	12,000
Provision for SIA Chronic Conditions	105,837
Health Promotion	12,457
Cancer Navigation & Support	47,413
Mental Health	29,630
HP Infrastructure	14,511
Immunization Enhancement	50,000
Smoking Cessation	17,000
Rural Premiums	90,800
Green Prescription	16,728
Totals	$396,376

These amounts will be carried forward for expenditure in the 2008 – 2009 financial year.

Finally I wish to express a special thanks to the PHO team for their hard work, 'can do' attitude and commitment, the hard working practice teams Coast- wide, the PHO Clinical Governance Committee and the funders who respect and support the work of the PHO. I also thank the Chair and PHO Board for their guidance and support during the year. Above all I thank the community for participating in the PHO programmes.

3.

Subsidising routine access to primary care

Aim: To improve access to primary health care services by reducing the cost per visit that patients pay themselves (copayments).

Target group: All people enrolled in the PHO (30,211 as of 30 June 2008).

Key activities:

- To pass on the funding for "first level services" to contracted practices, so that patients don't have to pay the full cost of their visits to the GP practice.

Progress in 2007-2008

- During the course of the year all GP practices elected to take-up the Very Low Cost Access (VLCA) funding, which further lowered the per visit payments made by patients themselves.
- The DHB approved the PHO's After Hours plan which covers the whole West Coast.

Cost of co-Payment as of 30 June 2008	
Under 6yrs	Zero
6 to 17 yrs	$10.50
Adult	$15.50

Outcomes measured

The PHO subsidised 107,072 visits by enrolled patients to its contracted medical centres during the year (this does not include visits by enrolled patients for accidents, which are funded by ACC, and nor does it include visits by patients who were not enrolled in the PHO, or who were enrolled but attended a different practice to their usual one). The visits (service utilization) increased by approximately 12% on the previous year. The average annual subsidy per enrolled patient was $140.33.

Source of funding: This programme is funded from the PHO's First Level Services funding.

Expenditure: **$4,072,545**

4.

Clinical Programmes & Services Report

4.1 Chronic Conditons

Diabetes Care

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

Target Group: All patients with diabetes.

Key Activities:

- To provide an annual review for patients with diabetes .
- To review both clinical management and self management of the patient's condition.
- To provide access to retinal screening for people with diabetes as near to their home as possible.
- 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 and outcomes.

Progress 2007-2008

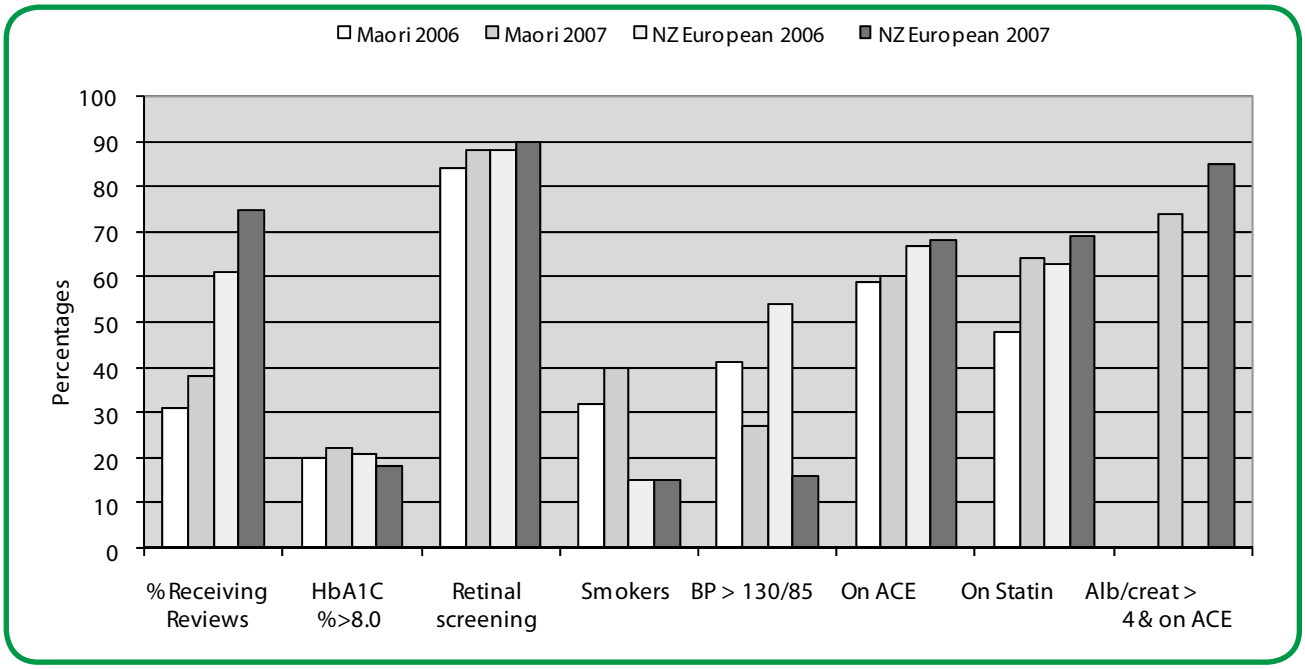
- In relation to diabetes annual reviews we are currently in a maintenance phase.
- Overdue lists continue to be sent to practices each month.
- There is continued positive uptake by practices of the generic 'My Shared Health Record'.
- All practices received a copy of the 2007 report reviewing diabetes annual review activity.

Outcomes achieved

(Clinical indicator reporting, under this contract, is from January to December)

- Across the PHO we reached our 70% target for number of annual reviews, with an increase from 549 to 690 checks.
- More patients are on statins to prevent cardiovascular events. Notably, the percentage of Maori on a statin has increased from 48% in 2006 to 64% in 2007.
- Overall rates of people smoking were unchanged; however, Maori were more than twice as likely to smoke than 'Other' , and reported smoking amongst Maori with diabetes has increased by 8% compared to 2006 (this may be influenced by an increase in reviews of Maori patients).
- Inequalities for Maori have reduced in relation to treatment provision compared to 2006, although the gap is widening in relation to HbA1c >8: in 2006 20% of Maori and 21% of NZ Europeans had a HbA1c>8; this year the figure has risen to 22% for Maori but dropped to 18% for non-Maori.

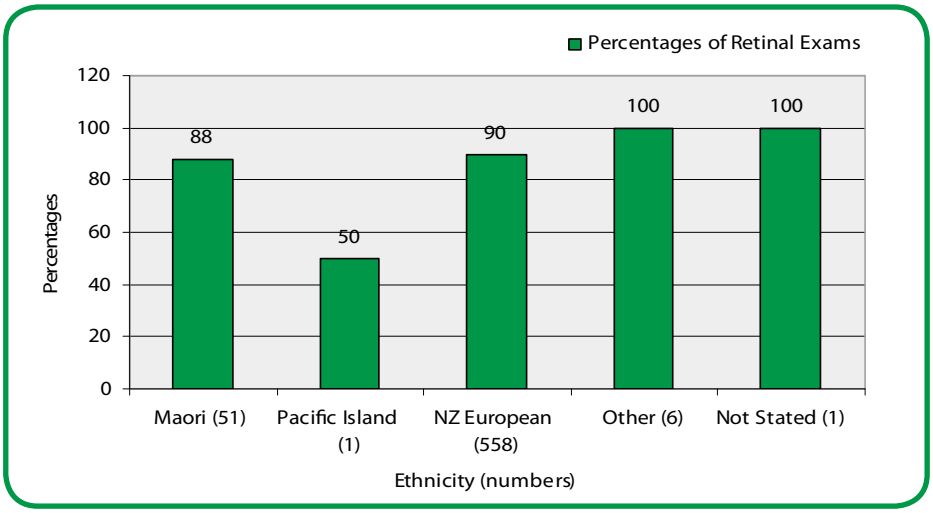
Annual Reviews by Ethnicity - 2006/07



The number of retinal screens from July 07 to June 08 was 451, with only 19 non-attendances.

Analysis of retinal screening by ethnicity is reported by calendar year.

Retinal Screening Rates By Ethnicity For 2007 (Calendar Year)



Diabetes Self Management Programme

It is well-established that people living with diabetes provide most of their own care. The diabetes self management programme provided by the PHO is a validated programme designed to improve the individual's (and their family/whanau) knowledge, self care skills and self confidence so they are better able to care for themselves. In 2007 a diabetes self management educator and two facilitators (one Maori) were appointed and trained to deliver programmes across the Coast. Between July 07 and March 08 the team delivered a course in each of the following centres: Westport (7 attended), Greymouth (7), Reefton (6) and Hokitika (for Maori) (3).

Source of funding: This programme is funded under a specific contract schedule within the DHB contract.

Expenditure: **$97,210**

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 revascularization, 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 decrease inequalities in treatment provision and health outcomes between high needs groups and the rest of the population with cvd.
- To ensure that these patients are receiving the most appropriate treatment regimes.
- To support these patients to self manage their condition more effectively by providing opportunities for collaborative care planning and goal setting.
- To link patients with lifestyle programmes that can support them to make any required behaviour changes – either pho based, provided by primary health care, or provided in the wider community.

Progress 2007-2008

- This programme is now embedded in primary care.
- Data analysis is now able to be undertaken.
- Planning around a more structured approach to chronic care management, based not only on an individual's clinical needs but their ability to self care, progressed well during the year. It is expected that this new approach will be implemented during the 2008-09 year.

Outcomes achieved

329 annual reviews were completed in the 2007-2008 year.

It is expected that practice-level provision of Maori cultural competence training and review of practice systems and processes planned for later in 2008 will increase the percentage of assessments for Maori in the coming year.

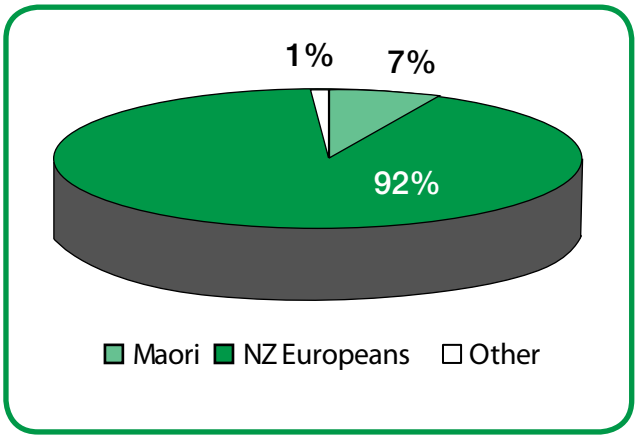
Myocardial infarction and angina made up 67% of all conditions identified as part of the clinical history of those having a CV Annual Review.

Of the 329 people receiving a cardiovascular annual review, 67% were prescribed a statin, 68% Aspirin, 59% an ACE inhibitor and 46% a beta blocker.

Source of funding: This programme is funded from the PHO's Services to Improve Access funding.

Expenditure: **$55,601**

Cardiovascular Annual Reviews By Ethnicity
July 2007 - June 2008



Cardiovascular Disease & Diabetes Screening

Aim: To identify patients at high risk of CVD and diabetes and work with these patients to decrease their risk.

Target Group: All individuals recommended 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 put in place a social marketing programme, planned with and aimed at maori and other high needs groups.
- To identify individuals who are at greater than 15% risk of having a heart event over the next five years, or with pre-diabetes.
- To ensure that these individuals are on the most appropriate treatment regimes.
- To support and empower these individuals to reduce their risk through participation in lifestyle programmes in the community, and care planning and goal setting in collaboration with their health care providers.
- To ensure that individuals at high risk have an annual assessment of their risk level.
- To decrease smoking, blood pressure, lipid levels and body mass index (bmi) and hence overall cardiovascular risk in these individuals.
- To decrease inequalities in treatment and in outcomes between high needs groups and the rest of the population at high risk.

Progress 2007-2008

- This programme is increasingly becoming part of routine primary care.
- Data analysis is now able to be undertaken.
- Practice visits to support practice teams with this programme continue.
- All technical problems with the software are essentially resolved.

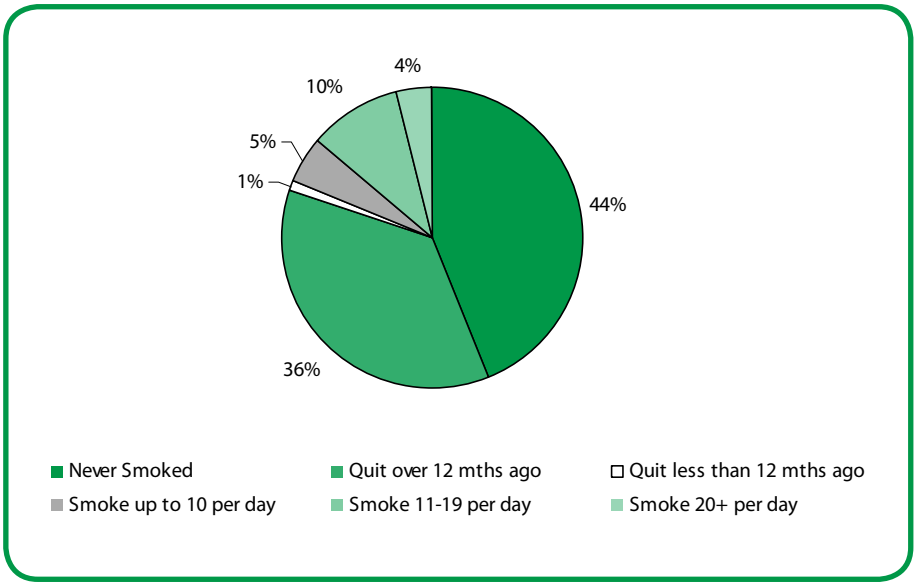
Outcomes achieved

- 1096 risk assessments were completed. Risk assessments include all initial screens, immediate follow ups for high needs and non high needs individuals, and annual risk assessment reviews.
- During the year seven percent of all risk assessments completed were for Maori. It is expected that the cultural competency training taking place at the practices and the social marketing workshop taking place later in 2008 will assist in increasing the number of risk assessments completed for Maori to a minimum of ten percent.
- Of those assessed over the year 33% were identified as having a five year cardiovascular risk level 15% or greater. This percentage is higher than expected, and these people will receive ongoing care as part of the programme to help reduce their risk.
- The condition most commonly identified during the cardiovascular risk assessment process was metabolic syndrome.
- The smoking status of those having a risk assessment or CVD annual review is illustrated in the following chart:

Source of funding: This programme is funded from the PHO's Services to Improve Access funding.

Expenditure: **$50,734**

Smoking Status Of Those Having A Cardiovascular Annual Review Assessment



Care Plus

Aim: To improve and/or maintain health and independence, relieve suffering, maintain people in their home environment and reduce inequalities in health status.

Target Group: Patients with two or more chronic conditions or with high primary care utilisation, who would benefit from more intensive primary health care.

Key Activities

Care Plus services offer the following benefits for patients:

- An initial in-depth review that includes a jointly developed care plan and ongoing support through quarterly reviews
- A focus on health outcomes and meeting personal health goals
- Low cost access to health provider expertise and time.

Care Plus offers the following benefits to practices and therefore patients:

- Funded time to provide a comprehensive review of the health status and management of patients and follow-up quarterly reviews.
- A structure for providing proactive and systematic attention to the health and social needs of patients.
- Opportunity to collaboratively develop a care plan with individual patients, promoting the partnership relationship between the patient and the health provider.

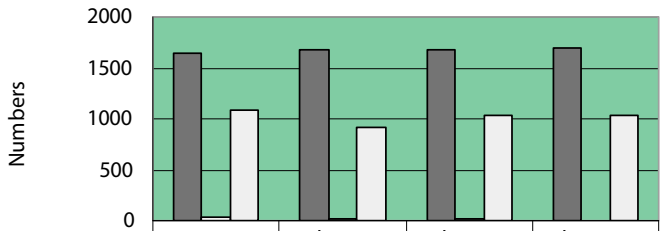
Progress 2007-2008

- The redesign of Care Plus into an integrated Chronic Condition Management Programme (CCM) has been completed and accepted by the Care Plus team at the MoH. The new CCM programme will be better able to monitor provision of evidence-based care and health outcomes. Its main focus will be on patients with cardiovascular disease and those with diabetes and/or chronic obstructive pulmonary disease.
- Information Technology to support the new CCM programme is nearly completed.
- Practices continue to be encouraged to enrol eligible patients onto the programme.
- The use of 'My Shared Health Record' continues to be extensive.

Outcomes achieved

On average during the 2007-2008 year 63% of available Care Plus places were utilized; the target is to utilize >80% of all available places for both total population and for Maori.

Utilisation of Care Plus Places 2007 - 2008

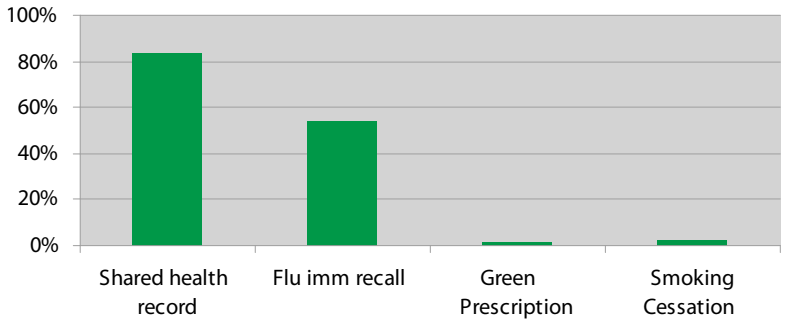


	1st quarter	2nd quarter	3rd quarter	4th quarter
Eligible for Care Plus and not HUHC	1647	1670	1679	1701
High user health card	28	21	11	8
Enrolled in Care Plus	1087	915	1040	1040

Time

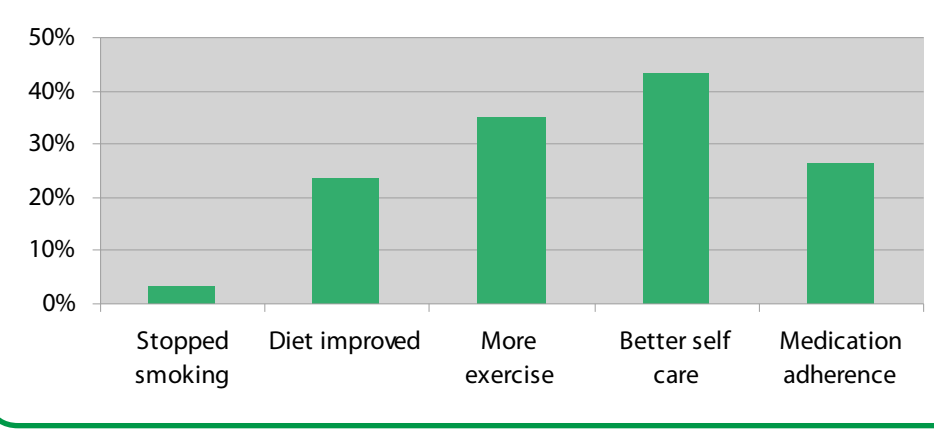
The utilization of 'My Shared Health Record' remains positive and there has been a 2% increase in uptake of flu immunization compared to the previous year. Referral to smoking cessation has seen no change but there was a decline in referral to Green Prescription from 3% to 1%. This is predicted to change due to the PHO taking over the Green Prescription contract for the 2008-09 year.

Current Interventions at Annual Review



This year saw improvements in all behavioural areas apart from the percentage of those enrolled who stopped smoking, which remains at 3%. There was an increase from 39% to 43% of individuals feeling better able to manage their condition(s). Thirty five percent of those enrolled felt they had increased the amount of physical activity they were undertaking compared to 32% last year, and improvements of a similar magnitude were reported in the areas of dietary improvement and adherence to medication.

Achievements In Last Year



Source of funding: This programme is funded under a specific, national contract within the DHB contract.

Expenditure: $196,402

4.2

Health Promotion

The Alma-Ata Declaration of 1978 identifies primary health care as the key to the attainment of the goal of "Health for All". Health promotion funding provided to PHOs assists them to establish health promotion interventions in collaboration with other health care providers e.g. DHB HEHA team, public health units, NGOs and the community at large to work towards the Alma-Ata vision.

HEHA Breastfeeding Initiative

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 health professionals workplaces.

Key Activities:

- Lactation consultancy.
- Peer support.
- Breastfeeding education sessions.
- Primary care training.
- Collaboration with community & public health for breastfeeding friendly workplaces and baby friendly cafes.
- Collaboration with the primary health sector and community.
- Connecting mother and baby with services at the right time.
- Co-ordination of breastfeeding action within health sector.
- Promotional activities.

Progress and Outcomes 2007 - 2008	
Lactation Consultancy	100 new clients, 199 follow-ups and returns
Peer Support	5 programmes, with 34 Mum4Mums trained
Breastfeeding Education Sessions	5 programmes, with 35 women plus partners/ family members

Primary Care Training:

- Presentations to all the gp teams on the lactation consultancy role.
- Study session in hokitika, and study day in greymouth, for all health providers.

Collaboration with community & public health on breastfeeding friendly workplaces and baby friendly cafes:

- 44 Cafes on the coast are baby-friendly.
- 2 Large workplaces are working on breastfeeding policies and facilities.
- Future collaboration on this project will be with the dhb heha coordinators.

Collaboration with the primary health sector and community

Collaboration has been extensive, with over 22 different agencies reached. The breastfeeding interest group includes representatives from pho, dhb, rata te awhina, plunket, well women's centre, midwives, breastfeeding support group and consumers. This group works together to protect, promote and support breastfeeding, especially around the world breastfeeding week.

Promotional activities:

- Attendance at the national baby friendly hospital initiative workshop
- Keynote speakers at the 2008 new zealand lactation consultants conference in wellington
- Presentation to the national health committee
- Involvement with the disability expo, and early childhood expo's, westport and hokitika.
- Articles in grey star.
- A postcard detailing lactation consultant availability to every regional contact of the national immunisation register.
- World breastfeeding week displays and presentations.

A moh funded evaluation of the service commenced in this annual period, ongoing into 2008/2009 year.

Source of funding: pho health promotion funding; dhb heha funding & dhb nutritional and physical activity funding.

Expenditure: **$48,959**

▶▶▶ Healthy Lifestyles

Aim: To increase participation in regular physical activity and promote healthy eating habits in the enrolled population of the PHO.

Target Group: Adults with a diagnosis of, or at risk of developing, CVD and diabetes.

Key Activities:

- to provide practice-based interventions for patients at high risk of, or with diagnosed, CVD and diabetes to support them to modify their lifestyles
- to link in with lifestyle support programmes provided by other community groups and primary care providers
- to increase the uptake of the Green Prescription and Smoking Cessation support programmes.

Progress 2007-2008:

- review of the utilisation of funded time to provide practice-based interventions for patients at high risk of, or with diagnosed, CVD and diabetes to support them to modify their lifestyles
- updating of the directory for practices on the nature, location, timing of and key contact person for physical activity programmes available in each region
- two more primary care staff trained in the Flinders self management programme.

Outcomes achieved

One Appetite for Life course was provided in Greymouth by a contractor; 14 women attended. The shortage of dieticians within the region has impeded the optimal provision of this programme but progress has been made to rectify this with collaborative efforts with the DHB and Community and Public Health. Due to underutilization of the Flinders self management support it has been decided to divert this funding into the Chronic Care Management Programme which will be implemented in 2008-09 year.

Source of funding: This programme is funded under a specific local contract schedule within the DHB contract

Expenditure: **$13,010**

Health Promotion Infrastructure

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

Target Group: DHB, Community and Public Health, PHO staff and providers, NGOs, and the West Coast community.

Key Activities:

- Jigsaw training for primary health care staff.
- Maori advocacy training, and evaluation of a collaborative approach to health promotion programme delivery.(these activities represented the completion of a 2006-07 one-off contract)
- men's health forums.
- youth sexual health project.
- several community collaborative health promotion initiatives.

Progress and Outcomes 2007-2008

- Twelve individuals completed Jigsaw (introduction to health promotion) training.
- Nine participants attended the advocacy training day for Maori in Westport.
- An independent evaluation of the collaborative approach to health promotion was completed by Dr. Doone Winnard, a Public Health Registrar. This evaluation is available upon request.
- Men's health forums were held in Reefton and Hokitika, attended by 214 men from a wide variety of backgrounds. The key messages were around heart health and the importance of having a cardiovascular risk assessment, and mental fitness. The DHB have agreed to fund a further three forums in the 2008-09 year in Franz Josef, Greymouth and Westport.
- Youth sexual health: this initiative included a poster competition, judged by students at Grey High School, with 520 copies of the winning poster distributed; and the distribution to high schools of nine sexual health kits.
- Several collaborative projects involving practices and pharmacies in community health promotion events were successfully completed.
- Diabetes Month: the PHO were represented at the three diabetes hui by the clinical manager and the diabetes self management team. The PHO was selected to facilitate four "Living Well" hui in the 2008-09 year.
- Heart Week: three heart health walks were held in the three main towns; there were media releases around cardiovascular risk assessments in local newspapers; a valentine verse competition was held, to encourage partners to have a cardiovascular risk assessment; finally, a "Raciest red receptionist" competition was held in the practices.
- Spring into Action: this year three practices entered teams and the PHO entered two teams into Spring into Action. In addition, all pharmacies on the Coast had bowls of free fruit promoting the 5+ a day message. Over a four week period, 144kgs of fruit was consumed.
- Smoke Free Month: all practice, pharmacy and PHO staff wore the smoke free tee-shirts one day a week during May to promote the smoke free message. In addition, all practice waiting rooms were decorated to raise awareness of smoking cessation during Smoke Free May.
- Healthy Lifestyle Ambassador Awards: three awards were presented to individuals in Westland, Grey and Buller districts.

Source of funding: These programmes were funded under a local contract with the DHB.

Expenditure: **$123,338**

Confidential Health Advice Team Support (CHAT)

Aim: To assist young people to obtain accurate health information, make positive decisions regarding their health, and access health professionals appropriately.

Target group: Young people in the Buller region.

Key activities:

- training and development of peer health workers through a variety of training activities
- supervision of peer health workers
- oversight of the programme.
- This programme was contracted to Buller REAP.

Progress in 2007-2008

- A high level of advice and support was provided by the CHAT team to a significant number of young people on a range of presenting issues, including stress and depression, relationships, legal issues, alcohol and drugs, sexual abuse, medical issues, and grief.
- Where indicated, a number of clients were referred-on to the programme co-ordinator, and to other services such as the GP, school guidance counsellor, mental health services, legal aid, etc.
- Training sessions included an intensive 3-day camp plus several other sessions throughout the year, and the development of a Code of Ethics for the programme.
- Individual and group supervision sessions were provided on a regular basis.
- The CHAT reference group met with staff from education and health services, as well as other government agencies and NGOs, and were involved with the MoH-funded Sexual Health Youth Voice Project.
- Team projects and promotional activities included an alcohol and drug-free dance party, the production of a video clip, and presentations to classes at Buller High School.

The PHO Board decided to discontinue ongoing funding for this programme in 2008/2009 due to other health promotion commitments requiring funding.

Outcomes achieved:

- 10-11 peer support workers (up to 4 Maori/Pacific Island)
- 115 clients assisted (62 female; 18 Maori), mostly in the age range 13 – 25
- 20 clients referred to other services
- 17 group and 14 individual supervision sessions
- 13 training events (including the 3-day camp)

Source of Funding: PHO Health Promotion funding.

Expenditure: **$19,900**

Smoking Cessation

Aim: To reduce tobacco smoking through increased availability of smoking cessation services in the community.

Target Group: All smokers on the West Coast but particularly high needs groups.

Key Activities:

- expanding the funding of this service to all smokers on the West Coast.
- increasing the number of smoking cessation providers within the primary health care setting.
- promoting the recording of smoking status within general practice.

Progress 2007-2008

- Target criteria were further broadened in December 2007, to encourage enrolments into the smoking cessation programme.
- A further 17 people have undertaken the PEGS training - five of these from pharmacies.
- A slight increase in funding from the DHB means more places can be offered in the 2008-2009 year.

Outcomes achieved

- 167 people enrolled in this programme: 92 (55%) were female and 17 (10%) were Maori.
- 87 (52% of those on the programme) enrolled via a pharmacy.
- 56 of those enrolled are at six months or greater since enrolment. Of these we have self-report outcome data on 48: 37 are still smoking, and 11 have quit.
- Excluding those for whom we have no data, this is a self-reported cessation rate after 6 months of 23%. This compares favourably with international quit rates.

Source of funding: PHO Services to Improve Access funding.

Expenditure: **$17,397**

Contraception & Sexual Health

Aim: To reduce teenage pregnancy rates and improve access to sexual health services.

Target Group: Young people 22 years and under requiring contraception.

Key Activities:

- to remove financial and social barriers to accessing contraception and primary sexual health services for young people, particularly those at highest 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.
- working 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 2007-2008

The focus this year has been on embedding the service in primary care and promoting its availability.

Outcomes achieved:

		06 - 07	07 - 08
Patients Seen	Total % Maori % Female	768 16% 96%	893 17% 97%
Age	Aged under 14 Aged 14 -15 Aged 16 -17 Aged 18 and over	1% 19% 33% 45%	1% 12% 35% 52%
Type	Emergency Contraception Oral Depo Condoms First visit/ Follow Up STI Check	11% 12% 22% 55% 67% / 33% 15%	7% 13% 25% 53% 64% / 25% 23%
Pharmacy	Script Claims Emergency Contraception	355 100	576 89

The number of individuals seen has increased by 125 (up 16%) from the previous year. There has been a slight increase in the percentage of individuals seen who are Maori.

Source of funding: This programme is funded under a specific, local contract schedule within the DHB contract.

Expenditure: $24,383

▶▶▶ Corrections Vouchers

Aim: To provide free acute care and general check-ups for very high needs patients, many of whom do not have a general practitioner.

Target Group: Clients of the Corrections Service.

Key Activities

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

Progress 2007-2008

This programme continues to benefit a very small number of high needs individuals.

Source of funding: This programme is funded from the PHO's Services to Improve Access funding.

Expenditure: $624

Outcomes achieved:

	06 - 07	07 - 08
Total Episodes	39	25
% Maori	23%	23%
% Male	74%	69%
Number of clients	25	13

4.3

Maori Health

Buller Kaiawhina

Aim: To improve access to primary health care services for Maori in the Buller region.

Target Group: All 800 Maori living in the Buller region.

Key Activities:

- to continue to identify & locate Maori not enrolled and missing out on health services/entitlements.
- Kaiawhina to visit homes & other relevant sites, engage, invite & encourage Maori to utilize routine primary health care services.
- increase Maori access to specific health services such as Care Plus, cardiovascular annual reviews, diabetes annual reviews, cardiovascular risk assessments, immunizations, etc.
- provide support to practice teams at Buller and Reefton Medical Centres, along with rural clinics in the region.

Progress 2007-2008

- Following the initial focus on enrolment, the Kaiawhina, in collaboration with the general practices in her region, is currently focusing on promoting the uptake of services to detect and monitor long term conditions. These include cardiovascular risk assessment, Care Plus, diabetes annual reviews and cardiovascular annual reviews.
- Further to this, the Kaiawhina has been increasingly involved in health promotion activities in the Buller, particularly linked to diabetes and heart health.

Outcomes achieved:

- increased Maori enrolments in the Buller region by 32%.
- winner of the Hauora Maori Innovation and Excellence Awards West Coast DHB 2007.
- nominated as a finalist in the Excellence in Primary Health Care section of the National Health Innovation Awards 2008; the winner of the award will be decided on 4th November 2008.

Outcome	Number
Maori incorrectly identified as non-Maori re-enrolled with correct ethnicity in Wesport	58
Maori newly enrolled	
Maori re-enrolled after 3 years	47
Children caught up with immunizations	6
Assisted with accessing the cervical smear programme	76
Referred to smoking cessation programme	17
Assisted with flu vaccination	8
Newly indentified diabetics and assistance with diabetes annual reviews	4
Newly enrolled in Care Plus	18
Cardiovascular risk assessments	8
Clients/Whanau assisted/accompanied to attend visits to BMC - First Quarter	9
Second Quarter	51
Third Quarter	53
Fourth Quarter	18
	27

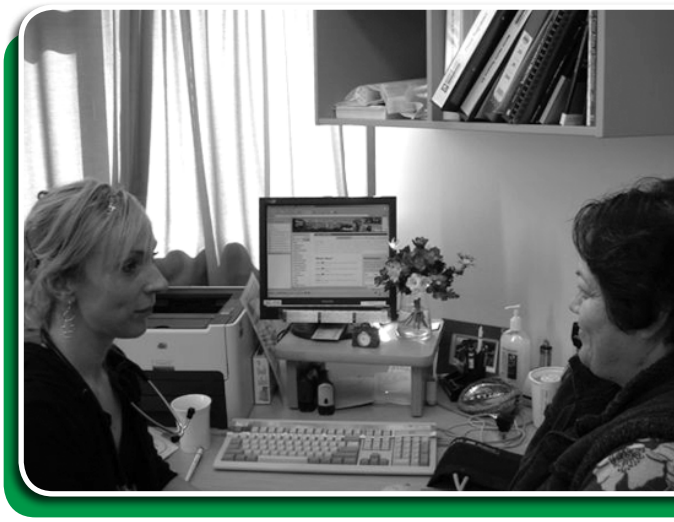
(The declining trend with this aspect of the Kaiawhina's service may be due to increased confidence by whanau in the medical centre)

Source of funding: PHO Services to Improve Access funding.

Expenditure: **$75,631**

Other Activities to Improve Health Outcomes for Maori

- consultation with Tatau Pounamu regarding new PHO clinical programmes.
- contracting out diabetes self management programmes to Rata Te Awhina Trust.
- funding made available to practices to audit the notes of Maori patients to ensure they were receiving the programmes and services they were eligible for.
- the PHO was contracted to provide a knowledge sharing report for the Primary Health Care Innovation Fund to share outcomes and learnings re the Kaiawhina role in the Buller region.
- reporting clinical programmes regularly according to ethnicity.
- the PHO utilizes the HEAT tool to facilitate equitable and fair processes around clinical programmes.
- reporting to practices re the numbers of Maori who have received their diabetes annual review, and their clinical management compared to the clinical management of non Maori.
- employment of a Kaihautu to work with Maori who have cancer and their whanau.
- the PHO was selected to facilitate four Maori hui with the kaupapa of 'living well'.
- the PHO corroboratively developed its new Maori Health Plan with a respected team of Maori and the General Manager of Maori health West Coast DHB. The plan aligns closely with the DHB Maori Health Plan and has annual measurable outcomes also reflected in the PHO 3 year Strategic Plan.



Mental Health Services

Aim: To support West Coast General Practice Teams (GPTs) to improve health outcomes and decrease inequalities for the enrolled population with mental health needs.

Target Group: Enrolled patients of West Coast practices with mild to moderate mental health concerns as identified by GPs and PNs.

Key Activities:

- Education and assistance to GPTs in relation to any enrolled patient with mental health issues.
- Up to five free counselling sessions for enrolled patients identified with mild to moderate mental health issues who meet criteria, plus a sixth follow-up session after six months.
- Presentations to GPTs and other groups/organisations on mental health issues.
- Workshops for primary health staff.

Progress 2007-2008

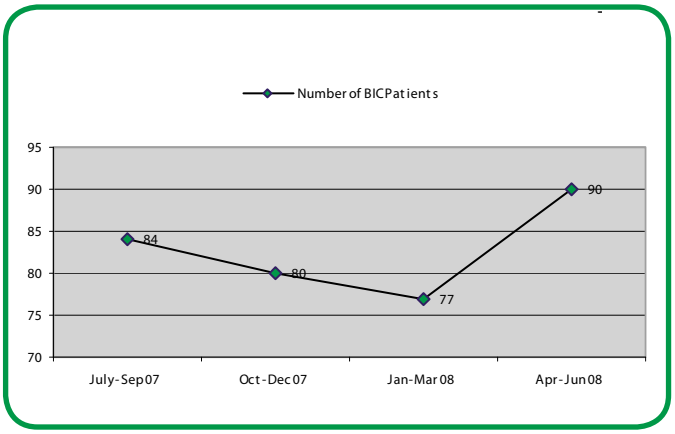
- Patients from all practices were seen by the GP Liaison Nurse who assesses and triages. Those who fitted the criteria for Brief Intervention Counselling (BIC) were then seen for BIC in their general practice rooms wherever possible.
- Mental Health Resource Kits were developed and distributed to every GP, PN, practice and clinic on the Coast in November 2007. Feedback has been very positive, some mentioning the patient handouts as being very useful, others finding the listing of local resources as being useful, while others mention the information and screening tools for mental health issues. These kits included patient handouts, lists of local resources, and information and screening tools for mental health issues. Feedback has been very positive.
- Ongoing liaison was held with government agencies, NGOs, and other community groups, as well as all general practices.

Examples of presentations:

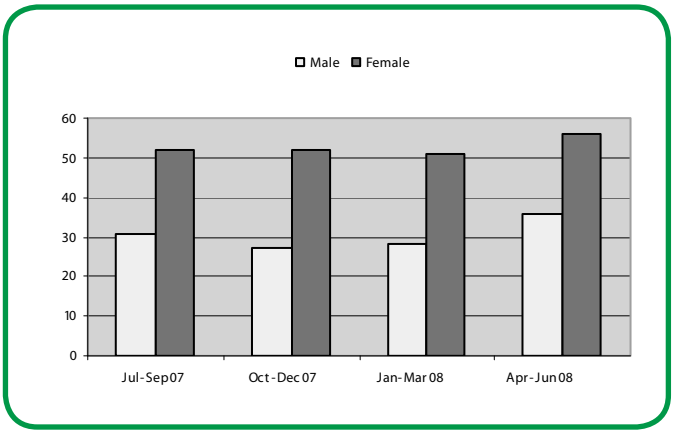
- CHAT group workshop, Charleston.
- 'Psychological Impact of Chronic Illness and Pain' at Post-Graduate Nurse training.
- 'The Hidden Disabilities' at Disability Awareness Day, Greymouth.
- WCPHO Mental Health Programme at Rural Health Symposium, Wellington.
- DHB sustainability work stream on Mental Health.
- Local workforce development plan for DHB child and adolescent mental health service.
- Group session for people bereaved by a suicide, Reefton.
- As well as supporting GPTs with their individual patients, a number of workshops were held for GPTs on topics such as: Coping with stress and change; Working together effectively; Setting objectives and action planning; Dealing with difficult people in the practice. Primary/secondary interface meetings were held at two practices.
- Following relocation of Greymouth Medical Centre, BIC commenced from the new premises. Claims for extended consultations by GPs and PNs totalled 25 from the November onset. These involved consultations of at least 20 minutes length on mental health issues.
- A registered psychologist has been appointed to a position providing BIC to young people. This will allow the age criterion for BIC to be reduced from 18 to 14 years.

Outcomes Achieved:

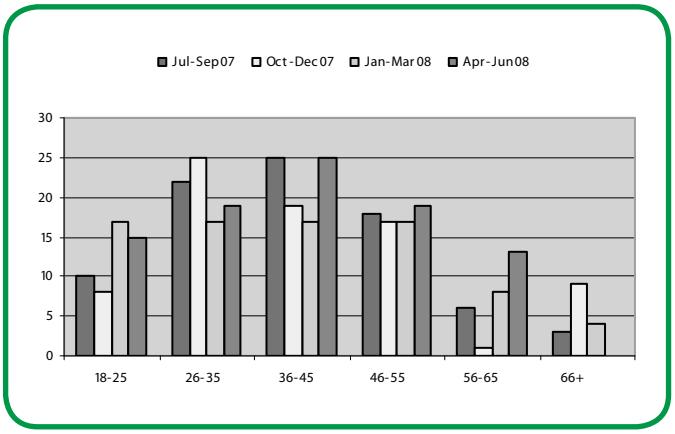
Table 1: Number of BIC Patients (Via Practices) Total 331



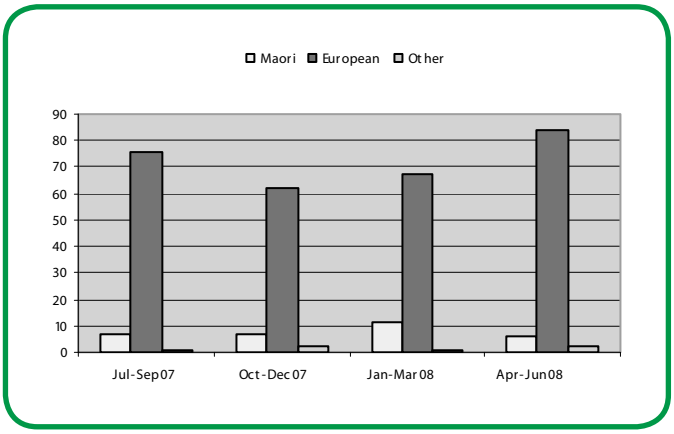
(Fig 1.) Gender Data 2007 / 2008



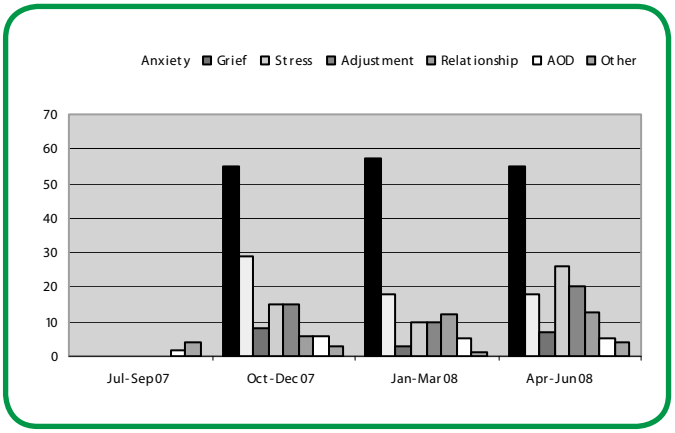
(Fig 2.) Age Data 2007 / 2008



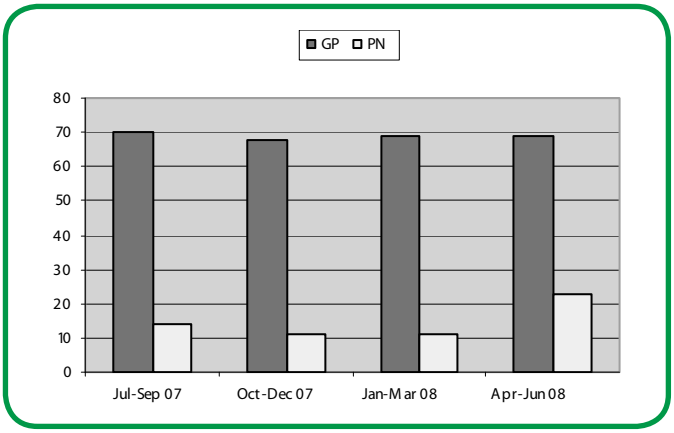
(Fig 3.) Ethnicity Data 2007 / 2008



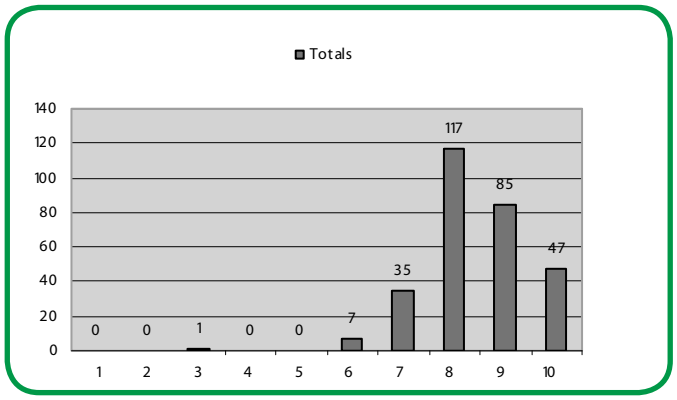
(Fig 4.) GP / PN Reasons For Requests



(Fig 5.) Number of requests from GP / PN



(Fig 6.) Deciles



The General Health Questionnaire 12 (GHQ12) was used as an evaluation measure and was given to people prior to commencing BIC, at the end of the last session of counselling, and at the six-month follow-up session. The GHQ12 has a possible total score of 36; the higher the score, the higher the psychological distress. Average data are given for these measures at the three different stages of counselling. These data indicate significant decreases in the level of distress after counselling and also indicate that the changes are maintained over time.

- Pre-counselling 23.78
- Post-counselling (5th session or less) 4.83
- Six-month follow-up (6th session) 5.42

Source of funding: Ministry of Health funding

Expenditure: $224,440

Mental Health - Ministry of Social Development (MSD)

Aim: To provide Packages of Care, notably Brief Intervention Counselling (BIC), to MSD clients.

Target Group: MSD clients in receipt of a Work and Income Benefit who are motivated to seek employment and have mild to moderate mental health issues.

Key Activities

- All MSD clients referred to the Mental Health Team are initially assessed by the GP Liaison Nurse.
- Those clients who meet the criteria are then offered a Package of Care which is mainly six sessions of BIC.
- Clients are seen for BIC in their general practice rooms where possible, with a back-up room available at the PHO office in Greymouth.
- Pre and post-BIC measures are taken for evaluation purposes using the Kessler10.

Progress 2007-2008

- An agreement between MSD (Work & Income) & WCPHO was signed for the period 1 November 2007 – 30 June 2008. The first two referrals were received on 23/11/08. By 30 June, 48 had been seen and 28 had received BIC.
- The Mental Health Team presented information about this MSD programme to each medical centre/clinic on the Coast during November/December 2007 and via emails in 2008 to all GPs and PNs in the practices.
- Meetings were held with Work and Income case managers in Greymouth and also in Westport to discuss the programme and the profiles of potential clients.
- MSD Minister Hughes visited the PHO on 11 June to discuss the programme.
- The programme was showcased at the MSD launch in Nelson as the first of its kind.

It is successful to date.

(Fig 1.) MSD Data 2007 / 2008

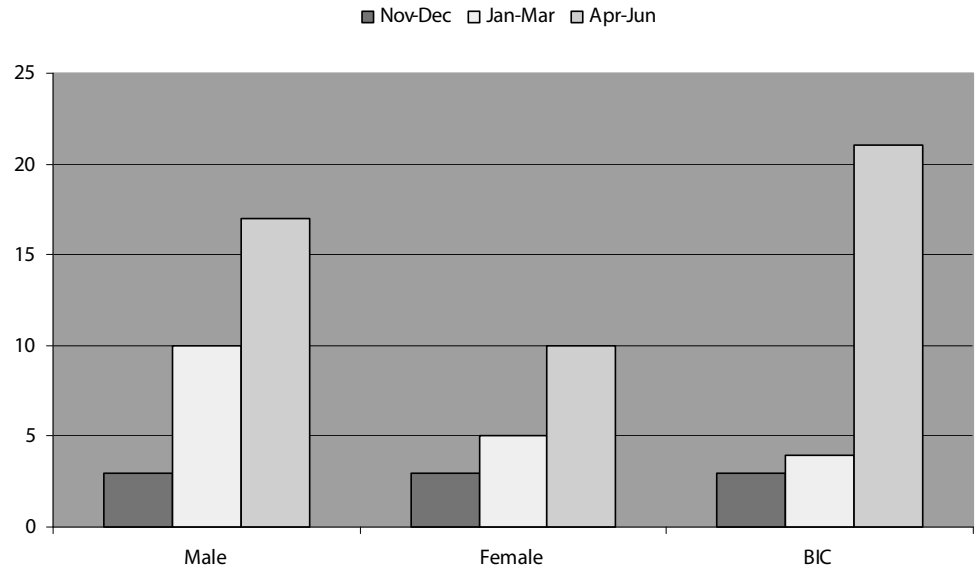


Fig 1 shows the number of beneficiaries (males and females) who participated in the program since November 2007, and the number who received BIC. The required evaluation tool for this MSD group was the Kessler10. The average score prior to commencing BIC was 26.4 and after receiving BIC it was 13.0, indicating significant decreases in psychological distress. The average number of sessions for packages of care was six.

Source of funding: Ministry of Social Development (MSD).

Expenditure: $36,000

Cancer Navigation & Support Services

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

Target group: People with cancer & their families/whanau.

Key activities

- Providing client-focused cancer support and social interventions in West Coast communities.

Progress in 07/08

This piloted programme has had 9 months of activity in this financial year. The programme has enabled the navigators to be responsive to the needs of those with cancer in the community in a targeted and timely manner. By providing a co-ordinated but flexible approach, the programme offers culturally sensitive effective resource use which empowers the individual to navigate their own course in collaboration with the professionals and the community.

To date the service delivery has been very well accepted by practices and clients alike. Strategic linkages and liaisons both in the sector and intersectorally continue to strengthen the overall quality of the programme.

Outcomes

- The West Coast pilot was the first to be implemented out of three nation-wide.
- 56 patients were enrolled in the first 9 months.

	Oct 07 - June 08
Face to Face contacts	602 hours
Phone contact	66 hours
Contacts on behalf (e.g with WINZ)	100 hours

Source of funding: Ministry of Health pilot funding over 3 years.

Expenditure: **$168,648** (programme commenced later than anticipated)

▶▶▶ Palliative Care

Aim: To relieve any potential financial barriers for patients and their whanau in the terminal stage of their illnesses

Target group: Patients with a terminal illness.

Key activities:

- Funding of terminal care clinics and home visits.

Progress in 07/08

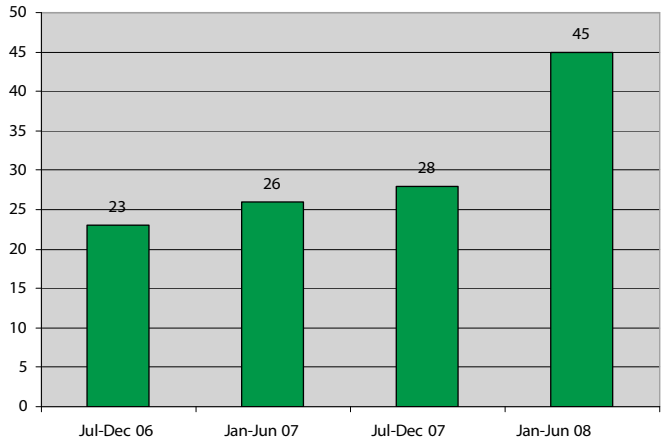
- This programme covers surgery, home visits and some part charges for medications used in a palliative setting for enrolled palliative care patients.
- All practices are now invoicing the WCPHO on a monthly basis.
- There have been three approved requests for further additional funding.

Outcomes achieved:

		2007 - 08
Patients cared for	Total	**80**
	% Maori	6.316%
	% Female	49%
Diagnosis	% with cancer	70%
	% other causes	36%
Type	No. home visits	192
	No. clinic visits	152
Location	Greymouth	39
	Hokitika	23
	South Westland	2
	Westport	12
	Reefton	4

The numbers of patients cared for under this programme has nearly doubled (48 last financial year). Average cost per patient is $338.00 which is an increase of 44% on the last financial year. The budget for this programme has increased 21% over this time.

Total Number of Patients



Source of funding: This programme is funded under a specific, local contract schedule within the DHB contract.

Expenditure: $16,423

5.

QUALITY IMPROVEMENT AND PROFESSIONAL DEVELOPMENT

5.1 Performance Management Programme

Aim: To achieve nationally agreed quality indicators.

Target Group:

Key activities

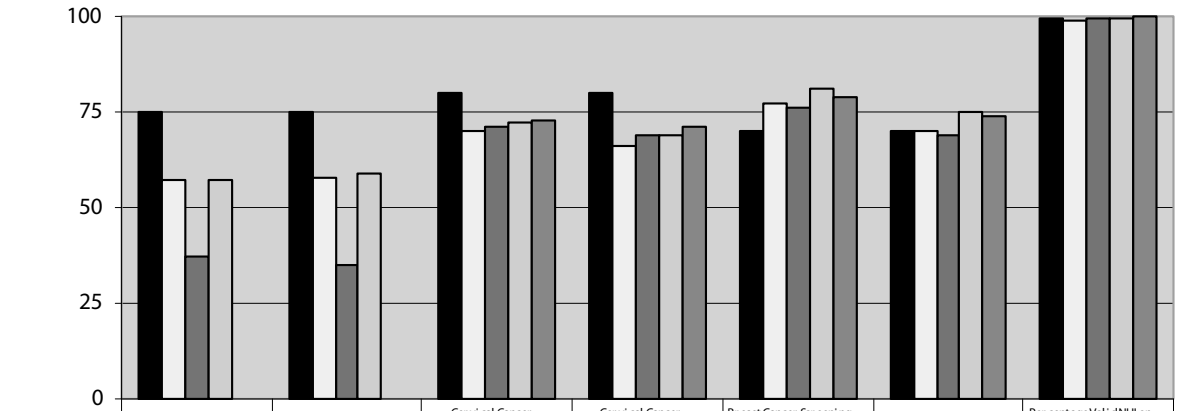
- Each practice has an established quality improvement team which manages their programme.
- A quality improvement plan is developed by each practice, which guides the practice's efforts for the year. This plan is submitted to the Clinical Governance Committee annually.
- Financial incentives, based on performance, are paid to practices for use in quality initiatives.
- Data is received from the national programme on the performance of each practice and their providers.
- Practice visits and group professional development sessions are held regularly.
- Pharmacists are paid to assist cost effective and appropriate prescribing.
- The programme acts as a catalyst to co-ordinate the activities of other programmes: cervical and breast screening, and immunisations (both childhood and influenza).
- Clinical facilitator, Dr Greville Wood, supports practices in the programme.

Outcomes

The large number of short term contract doctors working on the Coast each year has resulted in the local lead practitioners shouldering the major responsibility for achieving these targets. Against this backdrop of not only short term placements but also doctor shortages, the sustained and continued improvement in the parameters being measured is a tribute to the teams we have working in general practice. These results could not be achieved without an integrated team approach (administrators, nurses and doctors working together).

The following graphs reflect the progress the WCPHO has made since the inception of the performance management programme. The goal for each activity is indicated by the initial black column. We have achieved 2/3rds of the national targets that have been set.

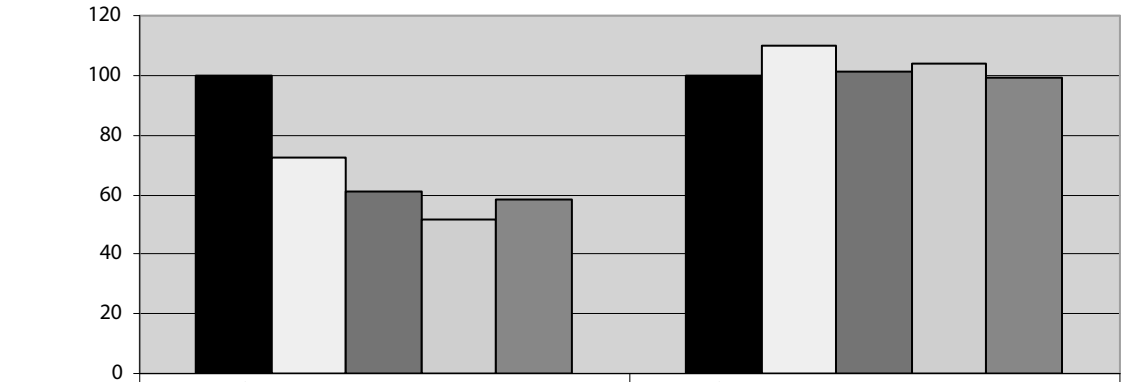
Indicators that measure Preventive Health activities.



	Flu Vaccine Coverage (Total Population)	Flu Vaccine Coverage (High Needs)	Cervical Cancer Screening Coverage (Total Population)	Cervical Cancer Screening Coverage (High Needs)	Breast Cancer Screening Coverage (Total Population)	Breast Cancer Screening Coverage (High Needs)	Percentage Valid NHI on Register (Total Population)
Programme Goal	75	75	80	80	70	70	99.5
31-Dec-05	57	58	70	66	77	70	99
30-Jun-06	37	35	71	69	76	69	99.2
30-Jun-07	57	59	72	69	81	75	99.26
			73	71	79	74	99.73

These indicators reflect a continued improvement in practice systems and engagement with our local enrolled populations. The NHI numbers are indicative of what can be achieved at a practice level; the final 20 – 25% shortfall in the other indicators requires a commitment from our communities to embrace these services.

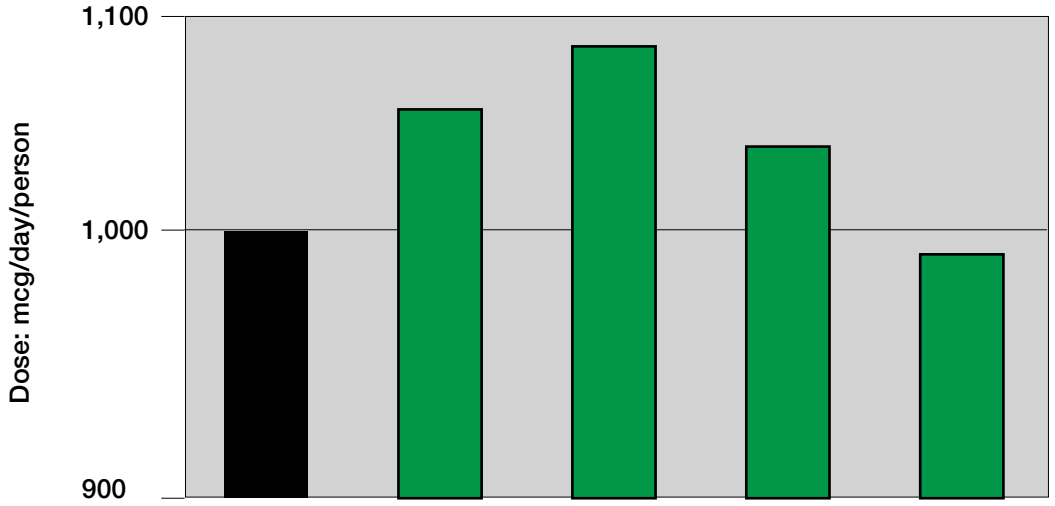
Indicators that measure Referred Services and Utilisation



	GP Referred Laboratory Expenditure Total Population	GP Referred Pharmaceutical Expenditure Total Population
Programme Goal	100	100
31-Dec-05	72.1	110.1
30-Jun-06	60.9	101
30-Jun-07	51.6	103.7
30-Mar-08	58.1	99

It is particularly pleasing that the total cost of prescribing on the Coast has dropped, despite an increase in the prescriptions for cardiovascular and diabetic patients.

Clinical Indicators



■ Inhaled Corticosteriods Total Population	Programme	31 Dec 05	30 June 06	30 June 07	30 March 08
	1,000	1,055.96	1,087.33	1,040.19	985.82

We have now achieved this milestone.

Source of funding: This programme is funded as per the national funding formula for PHO performance management programmes.

Expenditure: $74,279

5.2

Professional and Practice Development

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

Target Group: All members of the general practice teams.

Key Activities

- Professional development activities include local workshops/study days, local video-linked evening education sessions (coverage from Hokitika to Westport), and funded access to conferences and training opportunities mostly beyond the West Coast.

Local study days:

- The PHO Celebration Day in November 2007 featured presentations and displays on a wide range of topics, and was well-attended by practice and PHO staff and in the afternoon by the public. In total approximately 90 people attended throughout the day.
- All the practices were represented at the one-day workshop for practice administration staff in May 2008. A Breastfeeding study day was held in June 2008, with health workers from a range of agencies.
- Professional development meetings:
- Dr Anna Dyzel is contracted to co-ordinate and arrange the local continuing education sessions, with oversight from the Clinical Governance Committee and feedback from a CME needs survey.

Quality activities:

- Preliminary work is underway to assist practices over the coming year in their preparation of policies and procedures for Cornerstone accreditation.

Progress in 2007 - 08

Professional Development Meetings July 07 - June 08	
Topic	**Attendance**
Health promotion	12
Smoking cessation	13
Suicide Risk	12
Kiwi Saver	8
Performance management review	12
Problem gambling	5
Dyspepsia and heartburn	7
Return to work ACC	9
Breastfeeding	4
Paediatrics: intra-osseus injections	9
Family violence DSAC	12
STIs: contract tracing	11
COPD: spirometry	7
Ethical issues and frustrating cases	7
Action planning	14
Diabetes	23
Herpes and HPV	17
Sleep apnoea	12
PHO celebration day	15 (from practices only) 20
Practice administration workshop	15
Breastfeeding study day	
By Professional grouping:	
GPs	99
Nurses	72
Administration staff	74

Conference/course leave

The PHO provides funding to practices, based on practice size, for conference leave and training courses. This is available to all team members, and is widely utilised.

Participants	Topic
5 PN	Respiratory education workshops
2 PN	Respiratory and cardiac nursing course
6 PN	Spirometry course
2 PN, 1 RNS, 1 GP	PRIME training
2 PN	Sexual health course / certificate
3 PM, 2 PA	PMAANZ conference
2 PN	Immunization conference
3 PN	Vaccinator training
2 GP	RNZCGP national conference
1 GP	Advanced paediatric life support training
1 PN	Breastfeeding awareness course
2 PA	Red Cross first aid training
1 RNS	Emergency nurse conference
1 GP	GP conference in Melbourne
2 PA	CPR training ACLS course
1 GP	Paediatrics course
1 PN	Breastfeeding counseller training
2 GP	Primary Care update conference
2 GP	NZMA conference
2 PN	Child health assessment course
2 GP	Level 5 resuscitation training
1 PN	Enrolled Nurse study day
1 GP	Goodfellow conference
5 PN	Smoking cessation
1 PA	Steralisation and blood products
3 PA	Medtech training
5 GP, 1RNS	NZ Rural GP network conference
4 PN	Hormonal contraception
1 GP	New teachers meeting
2 PN	Chronic disease management course

Source of funding: This programme is funded under a specific local contract within the DHB contract.

Expenditure: $57,984

5.3

Work Force Retention

Rural Workforce Retention

Aim: To assist with retention and recruitment of all primary health professionals in rural communities.

Target group: Providers contracted to the PHO.

Key Activities:

- employ a PHO-wide locum to assist with locum coverage for GPs to take conference and holiday leave
- 2 GP registrar scholarships to attract young GPs to the Coast
- completion of After Hours Plan with the DHB
- PRIME training for more nurses, to extend after-hours on-call roster coverage
- distribution and update of generic recruitment pack
- ancillary support to practices (in extraordinary situations) for continuity of medical services.

Progress in 2007-2008

- PHO-wide locum services were available and well utilised for the first quarter only, due to the locum choosing to exit the contract for unavoidable reasons. The balance of funding was directed to other activities, including a project to review recruitment and retention issues and develop guidelines for relevant staff.
- Two GP registrar scholarship placements were completed.
- The After Hours Plan was finalized and approved by the DHB, but full implementation has been deferred pending the outcome of the DHB Sustainability Project.
- PRIME training was provided for two more nurses.
- A review is underway of the generic recruitment pack (as sent to all practices).
- Support with recruitment processes was provided to two practices.

Source of funding: Rural Retention Funding from Rural Premiums.

Expenditure: **$219,459 (Practice Payments $203,402; PHO Programme $16,057)**

Reasonable Rostering

The DHB devolved the reasonable rostering funding to the PHO in November 2007.

Aim: A flexible resource designed to maintain a sustainable workforce within primary health care in rural areas across the region.

Target group: Eligible service providers contracted to the PHO.

Key activities

- The DHB devolved this funding to the PHO in November 2007.
- The PHO paid the bulk of this funding to eligible practices and service providers.

Progress in 2007-08

- Payments made to eligible contracted practices and providers as above.

Source of funding: Reasonable rostering funding.

Expenditure: **$253,000** (from December 2007)

Rural Bonus

The DHB devolved the rural bonus funding to the PHO in November 2007.

Aim: A flexible resource designed to maintain a sustainable workforce within primary care in rural areas across the region.

Target group: Eligible service providers contracted to the PHO.

Key activities

- The DHB devolved this funding to the PHO in November 2007.
- The PHO paid the bulk of this funding to eligible practices and service providers.

Progress in 2007-08

- Payments were made to eligible contracted practices and providers as above.

Source of funding: Rural bonus funding.

Expenditure: **$37,556** (from December 2007)

Financial Statements

West Coast Primary Health Organisation Trust
For the year ended 30 June 2008

INDEX

WEST COAST
Te Tai o Poutini
Primary Health Organisation

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

Directory

As At 30 June 2008

PRINCIPAL BUSINESS:	Primary Health Organisation
ADDRESS:	P O BOX 544 163 Mackay Street GREYMOUTH
TRUSTEES:	Trustees at 30 June 2008 Anna Dyzel Judy Gimour (resigned 20/02/08) Maureen Pugh Tim Rochford Rosalie Sampson Tamai Sinclair Elinor Stratford (resigned 20/2/08) Richard Wallace Jo Spargo (resigned 20/02/08) Tony Coll (appointed 24/04/08)
INDEPENDENT CHAIRPERSON:	John Ayling
AUDITORS:	WHK Taylors DUNEDIN
SOLICITORS:	Chapman Tripp & Hannan & Seddon AUCKLAND GREYMOUTH
BANK:	Westpac Bank

Statement of Financial Performance

For the year ended 30 June 2008

	2008	2007
INCOME	$	$
Revenue	6,672,952	4,878,255
Interest Received	59,469	45,122
Grants Received	-	9,000
Sundry Income	28,454	-
TOTAL OPERATING INCOME	6,760,875	4,932,377
OPERATING EXPENSES		
Audit Fee	4,224	3,615
Bank Fees	947	104
Contract Payments	6,142,695	4,953,032
Insurance	7,093	5,706
Leases	78,708	-
Other Expenses	222,461	58,969
Trustee Meeting Fees	51,564	41,287
Trustee Reimbursements	14,949	16,277
Depreciation	37,591	-
	6,560,232	5,078,990
NET SURPLUS/(DEFICIT) FOR THE YEAR	200,643	(146,613)

WHK TAYLORS FOR IDENTIFICATION PURPOSES ONLY

Statement of Movements In Equity

For the year ended 30 June 2008

	2008	2007
	$	$
Net Surplus/(Deficit) For The Year	200,643	(146,613)
TOTAL RECOGNISED REVENUE AND EXPENSES	200,643	(146,613)
Equity at Beginning of Year	515,683	662,296
EQUITY AT THE END OF THE YEAR	716,326	515,683

WEST COAST PRIMARY HEALTH ORGANISATION TRUST

Statement of Financial Position

As at 30 June 2008

	Note	2008 $	2007 $
EQUITY		**716,326**	**515,683**
Represented By:			
CURRENT ASSETS			
Westpac Bank - Current Account		138,926	126,557
Westpac Bank - Saver Account		742,044	793,653
Accounts Receivable		320,905	121,532
Prepayments		3,853	3,791
TOTAL CURRENT ASSETS		1,205,728	1,045,533
NON-CURRENT ASSETS			
Property. Plant & Equipment	4	178,492	-
TOTAL NON CURRENT ASSETS		178,492	-
TOTAL ASSETS		**1,384,220**	**1,045,533**
CURRENT LIABILITIES			
Payables		208,547	155,239
GST Payable		62,971	14,499
Reserved Funding		396,376	360,112
TOTAL CURRENT LIABILITIES		667,894	529,850
NET ASSETS		**716,326**	**515,683**

Trustee
Date 18.9.08

Trustee
Date 18-9-08

WHK TAYLORS FOR IDENTIFICATION PURPOSES ONLY

Notes to the Financial Statements

For the year ended 30 June 2008

BASIS OF PREPARATION

The financial statements presented here are for the reporting entity West Coast Primary Health Organisation Trust. The Trust has been incorporated under the Charitable Trust Act 1957. The Statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand.

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

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

1 STATEMENT OF ACCOUNTING POLICIES

RECEIVABLES

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

INCOME TAX

West Coast Primary Health Organisation Trust is a charitable organisation and is therefore exempt from income tax under SEC CW34 of the Income Tax Act 2004.

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.

PROPERTY, PLANT & EQUIPMENT

All owned items of property, plant and equipment are initially recorded at cost and 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 & Furniture	9.5% -40% DV

Notes to the Financial Statements

For the year ended 30 June 2008

REVENUE

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.

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
* Judy Gilmour was an employee of Reefton Medical Centre, which is a sub-contractor to, and receives funding from, the PHO. Judy Gilmour resigned from the Board of Trustees on 20th February 2008.
* Jo Spargo is an employee of High St Medical Centre, which is a sub-contractor to, and receives funding from, the PHO. Jo Spargo resigned from the Board of Trustees on 20th February 2008.

3 CAPITAL COMMITMENTS AND CONTINGENT LIABILITIES

The PHO has contracted to purchase assets valued at $Nil (2007: $28,775).
There were no contingent liabilities at the balance date (2007: nil).

4 PROPERTY. PLANT & EQUIPMENT

	Cost	Depn	Accum Depn	2008 Bk Value	2007 Bk Value
Building Improvements	86,219	16,831	16,831	69,388	-
Motor Vehicles	15,733	4,720	4,720	11,013	-
IT & Plant	114,131	16,040	16,040	98,091	-
	216,083	37,591	37,591	178,492	-

Notes to the Financial Statements

For the year ended 30 June 2008

5 FINANCE LEASE COMMITMENTS

Non-cancellable finance lease commitments are:

	2008	2007
Current Portion	96,651	-
Non-Current Portion	177,079	-
	273,730	-

WHK Taylors

Audit Report

To the readers of the financial statements of the West Coast Primary Health Organisation Trust

We have audited the financial statements on pages 2 to 7. The financial statements provide information about the past financial performance of the Trust and its financial position as at 30 June 2008. This information is stated in accordance with the accounting policies set out on pages 5 and 6.

Trustees Responsibilities

The Trustees are responsible for the preparation of financial statements which fairly reflect the financial position of the Trust as at 30 June 2008 and the results of its operations for the year ended on that date.

Auditors' Responsibilities

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

Basis of Opinion

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

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

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

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

Unqualified Opinion

We have obtained all the information and explanations we have required.

In our opinion the financial statements on pages 2 to 7:

- comply with New Zealand generally accepted accounting practice;
- fairly reflect the financial position of the Trust as at 30 June 2008 and the results of its operations for the year ended on that date.

Our audit was completed on 18 September 2008 and our unqualified opinion is expressed as at that date.

WHK TAYLORS

Dunedin

WEST COAST
Te Tai o Poutini
Primary Health Organisation

West Coast Primary Health Organisation
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Telephone: (03) 768 6182