Annual Report 08 09

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 2009.

The West Coast Primary Health Organisation [PHO] is a not-for-profit charitable Trust which is funded through a variety of contracts by the West Coast District Health Board and other 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 community, Iwi, and provider interests in the decision making of the West Coast PHO.

In April of this year Trustees and staff of the West Coast PHO together with a wide range of people representing organisations with an interest in health on the Coast considered collectively how the needs of the population and in particular those who are deemed to have poor health status could be more effectively addressed. The outcome was an acknowledgement that there needed to be more collaboration between and across the various organisations involved in the provision of primary health care with a particular acknowledgement of the contribution made by the various non government organisations [NGOs].

The Chief Executive's report highlights the progress and gains in a number of services consistent with our various contractual obligations.

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

The West Coast PHO concluded the year with a small surplus, which will be reinvested back into health services and programmes for the coming year. The West Coast PHO has been advised post year end that a number of the fixed term service contracts and their associated revenues will either not be renewed (on account of the fiscal constraints confronting many of the Government Votes), or reduced. This will inevitably have an impact on the West Coast PHO which will require careful consideration in order to minimise the impacts on at risk and disadvantaged groups of the community.

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.

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.

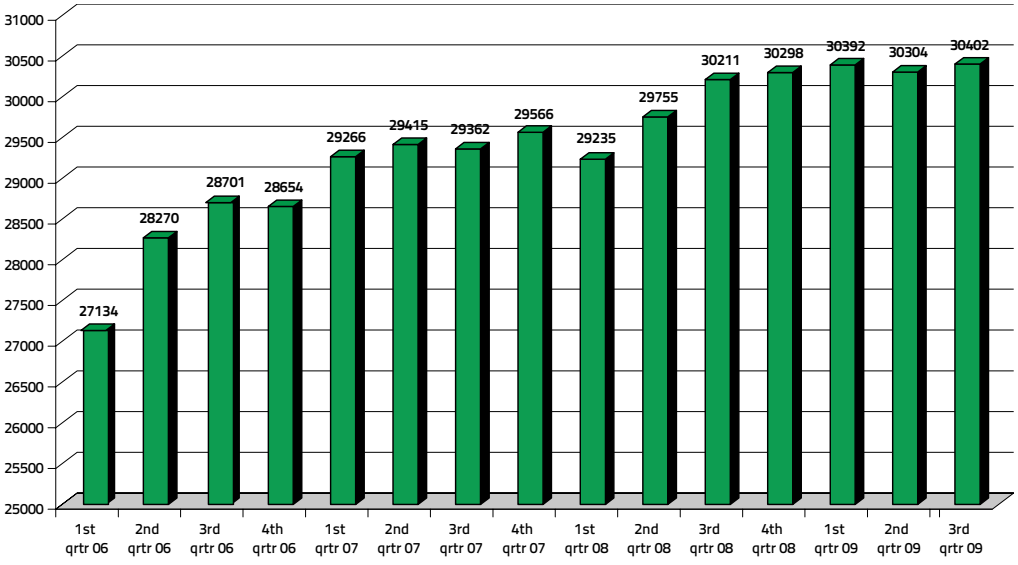
John Ayling
Chair

2. CEO's Management Report

The PHO has consolidated during the 2008-09 year with an increased number of community programmes being implemented either directly or through the general practices.

At the end of June 2009 the PHO enrolled population was 30,402, up from 30,211 at the beginning of July 2008, continuing the ongoing growth albeit small and plateauing so more people are enjoying the health and financial benefits of being enrolled in the PHO. Enrolment currently represents 97% of the eligible population.

Enrolled Population Over Time



All 8 general practices on the West Coast, from Karamea to the Haast, belong to and are contracted to the PHO and all of these practices remain Very Low Cost Access practices, which means ongoing lower medical and pharmaceutical costs to the community.

The following table shows the patient co-payment for a standard visit to the GP within normal office hours during the 2008/2009 financial year.

Under 6	$0
6 - 17yrs	$10.50
Adults	$16.00

Practice visits for 2008 to 2009 coast-wide totalled 119,333, approximately 59% of these visits being to a doctor and 41% to a practice nurse. This indicates a continuing trend of increased visits to practice nurses which means that GP practices are working with a greater team approach to healthcare. The number of visits to practices is up approximately by 10% from the previous year.

The PHO team increased from 15 staff as of 1 July 2008 to 19 staff as of 30 June 2009, based in Greymouth and Westport. Eighty percent of the staff are involved in clinical activity and/or direct delivery of health programmes.

The PHO delivered 25 community/clinical programmes in the financial year which represents the most amount of activity since the PHO commenced. The PHO is in a sound financial situation and innovative ways of funding and service delivery are already in place which should bode well within a current changing health environment. Of note, the PHO purchased their first GP practice during the year, recognising the need to improve timely access to primary care. The practice hopes to be ready for new enrollees by the end of October 2009.

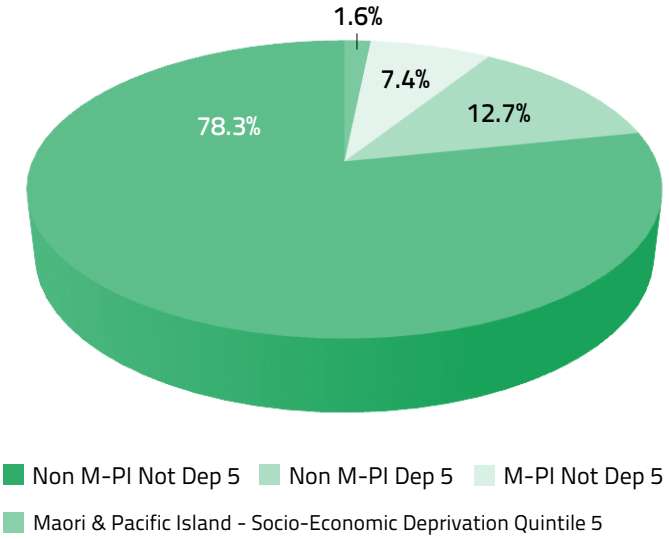
The PHO Clinical Governance Committee has strengthened and continues to recommend new PHO clinical and community programmes to the PHO Board for implementation. The Clinical Governance Chair has made special note of the progress that practices have made with the PHO Performance Programme which includes immunisation rates, mammograms, spend of pharmaceuticals etc. This progress has been made even though some practices have had ongoing challenges with recruitment and retention of clinicians.

Four of the most significant activities, among many others, of the year have been the rolling out of the Long Term Conditions Management programme, the huge success of the Green Prescription programme, the Men's Health Forums and the Breastfeeding service.

The Long Term Conditions Management Programme offers GP practices more funding to allow for closer monitoring and self management support for people with long term conditions, e.g. heart disease, diabetes and respiratory disease. Patients with a long term condition have an annual review or check up and then receive a package of care based on their level of need. For patients this means GP practice teams can provide more structured supports so that people living with a long term condition can manage in their own home and have a better quality of life.

Make up of Enrolled Population for Last Quarter

1 July 2008 to 30 June 2009



The Green Prescription programme's overall aim is to support and empower people who are inactive and/or at risk of heart disease, diabetes or with respiratory disease to participate in regular, safe community-based physical activity. Exercise programmes are individually designed for each person at an initial face-to-face visit, with ongoing telephone support. Programmes can be delivered individually or in a group setting. The key to Green Prescription is being able to support people to independently manage their own activity once graduated from the service.

The four Men's Health forums, focusing on preventative health issues specifically for men, attracted 388 men to attend the forums Coast-wide; of that number, 195 men attended a forum at the Stockton mine. This supersedes the previous year and this successful initiative was delivered on a $12,000 budget for four forums.

The PHO breastfeeding programme and lactation consultancy has contributed in a significant way to the DHB exceeding targets for infants being fully breastfed for under 6 weeks of age and under 6 months of age.

Any financial surpluses for the financial year will be carried forward for expenditure on programme and service delivery in the 2009/2010 financial year.

Finally I wish to express a special thanks to the PHO team for their hard work and commitment to their roles, the hard working practice teams Coast-wide, the PHO Clinical Governance Committee and the DHB and funders who 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 and gaining value from the PHO programmes.

Andrea Baker
CEO

3. Subsidising Routine Access to Primary Care

Aim
To improve access to primary health care services by reducing the cost that patients pay per visit (co-payments).

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 2008-2009
- During the course of the year all general practices remained Very Low Cost Access (VLCA), which maintained the lower per-visit payments made by patients themselves.

Cost of co-payment as of 30 June 2008

Under 6	$0
6 - 17yrs	$10.50
Adults	$16.00

Outcomes achieved
The PHO subsidised 119,933 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 10% on the previous year.

Source of funding
From the PHO's First Level Services funding.

Expenditure
$4,506,811

4. Clinical Programmes and Services Report

4.1 Long Term Conditions Management (LTCM)

LTCM Programme Enrolments

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

Target group
All patients with cardiovascular disease, diabetes or chronic obstructive pulmonary disease.

Key activities
- The redesign of Care Plus and integration into the Chronic Condition Management Programme, now called Long Term Conditions Management Programme, was completed in December 2008. General practice teams have been using this programme since April 2009, with the following aims:
- to stratify individuals into one of three levels of care depending on the complexity of their health problem and ability to self-manage their condition;
- to provide an in-depth annual review for each condition and then deliver a package of care based on level of need;
- to provide a jointly developed care plan called 'My Shared Health Record' for each patient;
- to refer patients to other PHO programmes or community support programmes as required.

Progress 2008-2009
- Information Technology to support the LTCM programme was completed, tested and implemented in early 2009.
- First enrolments into the LTCM programme began in March 2009 (one practice), thus reporting numbers are low at this early stage in the programme.
- Full training and support is being provided to all general

practices teams for the new LTCM programme.

Outcomes achieved

- Of the 416 people enrolled in the three months since March 2009, 96% are aged 45+ years.
- Enrolments are made up of 82% NZ European, 6% Maori and 12% Other Ethnicity.

Source of funding

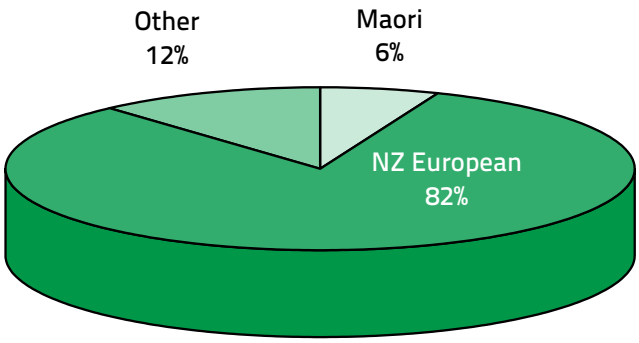
Services provided as part of the LTCM group of programmes are funded by Care Plus, Diabetes Annual Review, Services to Improve Access and a specific DHB contract for Level 3, Smoking Cessation, and Healthy Lifestyles.

Expenditure

$493,981

LTCM Enrolments by Ethnicity

Mar - Jun 2009



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 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 outcomes.

Progress 2008-2009

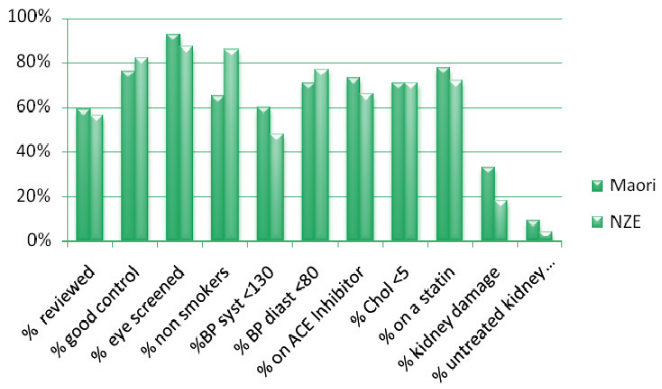
- There has been a lot of emphasis on diabetes annual reviews since the introduction of the Long Term Conditions Management Programme in March.
- Practices receive quarterly reports on annual review activity.
- Practice teams now have nurse-led clinics for diabetes annual reviews.
- A new contract was negotiated, with Matthews Eyewear & Eyecare, to provide the mobile retinal screening service.

Outcomes achieved

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

- The number of reviews was slightly down from the 2007 calendar year (672 vs 690), thus falling short of our target of 70% annual reviews completed.
- For the first time the Maori review rate was greater than for NZ European: 59% vs 56%.
- Maori smoking rates have decreased from 40% in 2007 to 35% in 2008.
- More patients are on statins to prevent cardiovascular events. Notably, the percentage of Maori on a statin has continued to increase: from 64% in 2007 to 78% in 2008.
- The target of up-to-date retinal screening for 85% of patients was met, with 87% of patients being screened within the last two years (93% for Maori).

Inequalities for Maori have reduced in relation to treatment provision with some indicators showing higher rates for Maori as per the following graph:



Diabetes Self Management Education Courses

It is well established that people living with diabetes provide most of their own care. The diabetes self management education (DSME) courses provided by the PHO are designed to improve the individual's (and family/whanau) knowledge, self care skills and self confidence whilst living with diabetes. In 2008 four facilitators delivered six courses in the following centres: Westport (1), Greymouth (2), Reefton (1), and Hokitika (2), with a total of fifty people attending overall.

Opposite are some outcomes of participants of the courses.

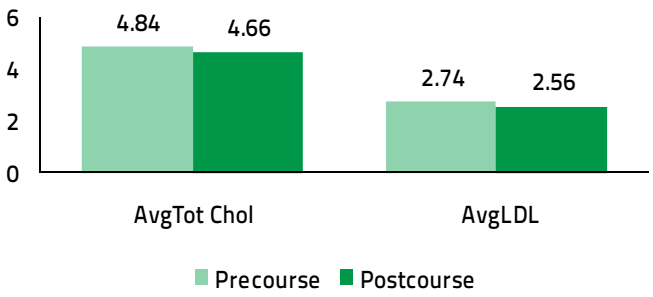
Source of funding

Funded as part of LTCM programme.

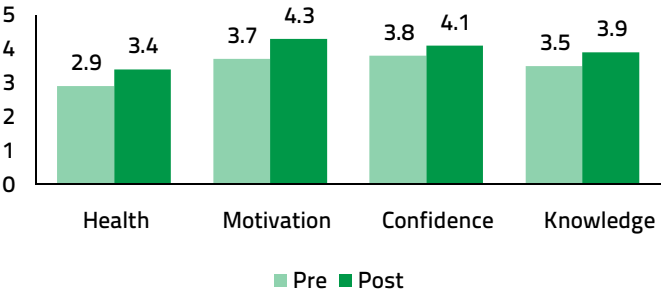
Expenditure

$48,805 for Retinal Screening; other diabetes services expenditure is a part of the $222,169 total LTCM programme expenditure.

Cholesterol outcomes following DSME course



Pre and post scores on health & attitude questionnaire (higher is better)



Chronic Respiratory Disease: COPD Annual Reviews

Aim

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

Target group

All patients with COPD.

Key activities

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

Progress 2008-2009

- Annual reviews for COPD patients began in all practices in April 2009.
- New information technology with clinical decision support was installed and trialled.
- A COPD study day was held for all practice staff.

Outcomes achieved

- The first annual reviews began in March 2009, giving only four months of data, thus reporting numbers are low and no clear conclusions can be drawn at this early stage.
- Of the fifty people reviewed from March to June 2009, 88% had a flu recall made, 96% had been given a COPD management plan, and 8% were Maori.

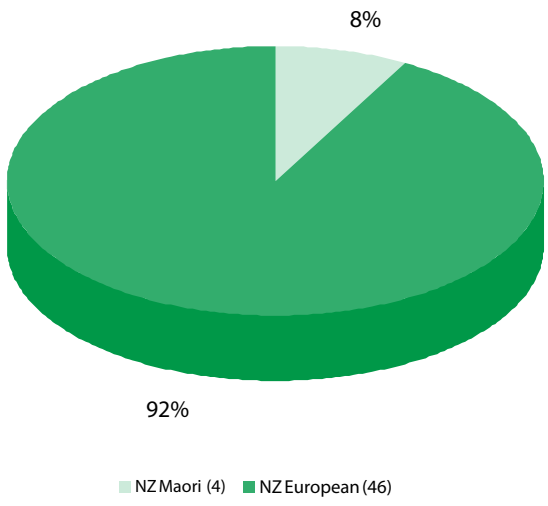
Source of funding

Funded as part of LTCM programme.

Expenditure

Included in the $222,169 total LTC expenditure.

COPD Enrolments March - June 09



Cardiovascular Disease Annual Reviews

Aim

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

Target group

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

Key activities

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

Progress 2008-2009

- CVD annual reviews are now well established into the Long Term Conditions Management programme. Patients are receiving individualised care based on their clinical need as well as their ability to self-care.
- All practices including rural clinics are now carrying out CVD annual reviews.
- Practices receive quarterly reports on their CVD activity.

Outcomes achieved

- 529 annual reviews were completed in the 2008-2009 year compared with 329 reviews in the previous year.
- Myocardial infarction and angina made up 67% of all conditions identified as part of the clinical history of those having a cardiovascular annual review.
- Of the 529 people receiving a cardiovascular annual review, 75% were prescribed a statin, 75% Aspirin, 51% an ACE inhibitor and 48% a beta blocker.

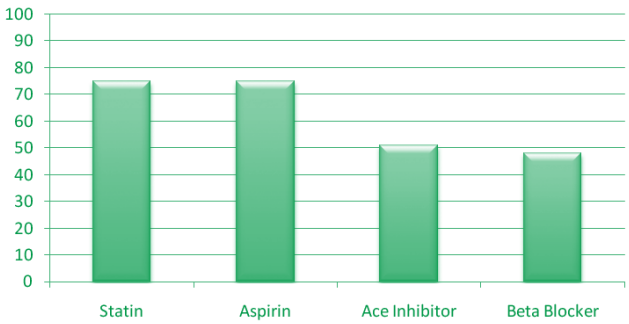
Source of funding

Funded as part of the LTCM programme.

Expenditure

Included in the $222,169 total LTCM expenditure.

% of people reviewed on preventative medication



Cardiovascular Disease and Diabetes Screening

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

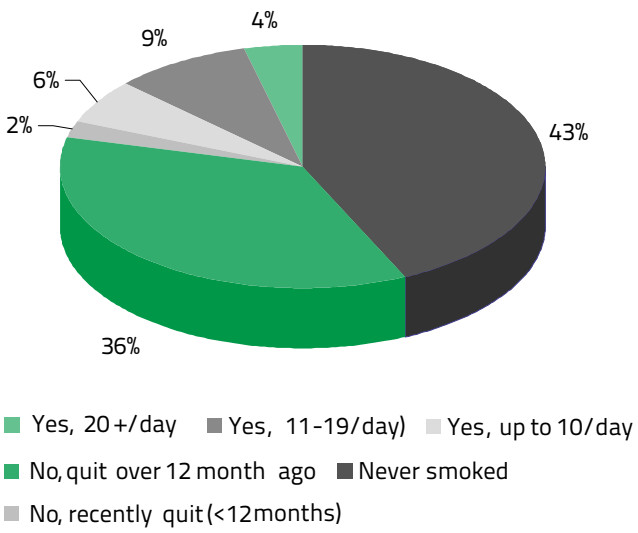
Target group
All individuals recommended by the national assessment and management of cardiovascular risk guideline, with particular emphasis on high needs groups including Maori and Pacific.

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

Progress 2008-2009
- This routine screening is available at all practices; either a General Practitioner or Registered Nurse can provide this service.
- Many people with high risk are referred on to Green Prescription to help them become active, and to smoking cessation services.

Outcomes achieved
- 1398 screens were completed in the 2008-2009 year, compared with 1096 in the previous year. Risk assessments include all initial screens, immediate follow-ups for high needs and non high needs individuals, and annual risk assessment reviews.
- 6% of all risk assessments completed were for Maori.
- Of those assessed over the year, 21% were identified as having a five year cardiovascular risk level of 15% or greater.
- The condition most commonly identified during the risk assessment process was metabolic syndrome.
- The smoking status of those having a risk assessment or CVD annual review is illustrated in the following graph:

Smoking Profile (YTD: 1/7/08 - 30/6/09)



Source of funding
This programme is funded by Services to Improve Access funding.

Expenditure
$123,318

Smoking Cessation

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

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

Key activities
- completion of the evaluation of the PEGS smoking cessation programme;
- preparations to modify the smoking cessation programme to a West Coast based programme called Coast Quit (being launched early September), incorporating the recommendations of the PEGS evaluation;
- all practices are now recording smoking status for their patients;
- smoking cessation services are now being provided by a number of nurses, GP's, rural nurse specialists, pharmacists and pharmacy staff across the West Coast.

Progress 2008-2009
- Heart Foundation 2 day smoking cessation training was held in Greymouth.
- Training on motivational interviewing for behaviour change was delivered to providers of smoking cessation services.
- 250 places on Coast Quit were available for the 2008-2009 year.

Outcomes achieved
- 246 people enrolled in this programme: 56% were female and 44% were male.
- Of the 246 enrolments, 6% were Maori.
- 60% enrolled with a local pharmacy, and 40% with a practice or clinic.
- Self-reported quit rates at 6 months were 32% for those interviewed in the PEGS evaluation, or 22% if those not interviewed are counted as not quit. This is a very good result for this sort of programme.

Source of funding
This programme is funded as part of the LTCM programme.

Expenditure
$23,707

4.2 Other Clinical Services

Contraception and Sexual Health

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

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

Key activities
- to remove financial and social barriers to accessing contraception and primary sexual health services for young people;
- 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 2008-2009
- Programme was extended for young people up to 25 years in the Franz Josef and Fox Glacier areas only. It was identified that people using the service there were predominantly in the 18-25 year age group.

Outcomes achieved

		07-08	08-09
Patients seen	**Total**	893	953
	% Maori % Female	17% 97%	18% 97%
Pharmacy	Script claims Emergency Contraception	576 89	490 109

The number of individuals seen has increased by 60 (up 7%) from the previous year.

Source of funding
Within the core PHO Contract.

Expenditure
$29,224

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 2008-2009
- This programme continues to benefit a very small number of high needs individuals.
- Programme processes and reporting forms have been reviewed and improved.

Outcomes achieved

	07-08	08-09
Number of clients	13	17
% Maori	23%	35%
% Male	69%	71%
Total episodes	25	22

There were no vouchers issued for the first quarter, 1st July to 30 Sept 08. Despite a drop in total episodes, the actual number of clients seen was more than last year.

Source of funding
From the PHO's Services to Improve Access funding.

Expenditure
$602

Rural Pharmacy Facilitator Project

Aim
A 12-month Ministry-funded project to explore new ways to utilize the community pharmacy role, and to improve the integration of care between practices and pharmacies.

Target group
Pharmacists and health care providers in the practices.

Key activities
Two consultants from Comprehensive Pharmaceutical Solutions were engaged to undertake a literature survey and to conduct individual interviews and focus groups with major stakeholders (pharmacists, GPs, practice nurses, Maori, consumers), in order to:

- explore how community pharmacy can better integrate with general practice on the West Coast, bearing in mind the major geographical challenges;
- identify the medication management needs of people with chronic conditions living in this rural area;
- identify the facilitators and barriers for community pharmacists in undertaking medication utilisation reviews on people with chronic conditions, and to develop a sustainable model for this;
- develop a minor ailments strategy for the region to address the over-use of general practice for minor ailments.

Progress 2008-2009
- Project specifications finalised and rural innovation funding grant obtained by August 2008.
- Consultants engaged by November 2008.
- Literature survey, key informant interviews and focus groups completed by April 2008-2009.
- Detailed written report, "Opening the Door on Community Pharmacy", presented to the Clinical Governance Committee (CGC) by June 2009.

Outcomes achieved
A working party from the CGC (including a pharmacist) has met to consider the report. Several recommendations in the report are already being implemented, and further consideration is being given to recommendations about the prescribing process, to improve efficiency and reduce errors.

Source of funding
This programme has been funded from a Rural Innovation Fund grant of $50,000.

Expenditure
$43,918

Immunisation Enhancement Project

Aims
To improve immunisation coverage rates for 2-year-olds, 11-year olds, and influenza vaccinations; and to assist practices with the HPV vaccination programme for females born in 1990 and 1991.

Target group
General Practice and PHO staff; midwives and well child providers.

Key activities
- visiting all practices and working with key staff to develop robust immunisation systems, including enrolment and recall;
- ensuring practice teams understand the new immunisation schedule;
- promoting education to key groups such as midwives and well-child providers;
- promoting antenatal visits to GPs by expectant mothers, so they can receive positive immunisation messages;
- improving the integration between social services involved in well-child health;
- assisting with the development of local communication strategies to promote uptake of free influenza vaccination;
- assisting practices to achieve 85% uptake of HPV vaccination of females born in 1990 and 1991.

Progress 2008-2009

- All practices were visited to review immunisation process systems, and draft policies were formulated for further consideration.
- 5 practices have undertaken audits of 11-15 year olds, to ascertain immunisation coverage rates.
- All practices have identified those eligible for HPV vaccination, and sent letters to them.
- Networking to promote immunisation occurred with a number of primary health providers outside the practices, as well as several community groups and agencies across the West Coast.
- A detailed report on the project was prepared, to be reviewed by the Clinical Governance Committee in July 2009, with a recommendation for wider circulation.

Outcomes achieved

- Immunisation processes have improved in many practices over the course of the project.
- Immunisation uptake for under-twos has improved overall.
- Influenza vaccination coverage reached 63% in May 2009 - an improvement on previous years.
- 11-year-old immunisation coverage improved during the project from 63% to 84%.

Source of funding

One-off DHB Contract of $50,000.

Expenditure

$54,607

4.3 Health Promotion Programmes

Health Promotion Community Activity

Aim

To build health promotion infrastructure that advances the Primary Health Care Strategy, and to implement collaborative projects.

Target group

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

Key activities and outcomes, 2008-2009

- Oranga Pai/Living Well Hui, held in Hokitika, Greymouth, Reefton and Westport. The Westport Hui was held in conjunction with Children's Day, with over 800 people attending.
- Men's Health Forums: forums held at Franz Josef and in Greymouth attracted 193 men. The Stockton Mine in Buller captured 180 men (and 20 women) at their workplace. Topics covered at these presentations included cardiovascular risk, cancer, and mental well-being, as well as smokefree promotion.
- Several collaborative community health promotion initiatives included 'walk to work day', 'Bikewise month', the CCS Christmas tree PHO display in all three regions and the Buller High School Health Expo.
- Heart Week included three heart health walks in the three main towns; 'chalk talk' promotions with heart check messages on the pavements around the three main towns; and walk-about red heart sandwich board promotions in the regions, with fruit distributed to members of the community.
- Smoke Free May: all practices decorated their waiting rooms to raise awareness of smoking cessation during Smoke Free May; and the PHO participated with the DHB in extensive promotion of smokefree workplaces, with sample baskets of NRT advertising 'Give Quitting a Go'.
- Spring into Action: this year 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.
- Influenza Vaccination Promotion: media releases went out to all regions promoting the benefits and dispelling myths around influenza vaccination; promotional 'stalls' were held at the Warehouse and Fresh Choice in Greymouth; and thermometers showing targets were displayed in the three centres and practices.
- Healthy Lifestyle Ambassador Awards: three awards were presented to individuals in Westland, Grey and Buller districts.

Source of funding

This programme is funded from the PHO core contract and the Health Promotion Infrastructure contract.

Expenditure

$174,208

Green Prescription

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

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

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

Progress 2008-2009
- Information Technology database installed and operational.
- Administration processes reviewed and enhanced.
- Quarterly newsletters and Green Prescription updates sent to all practices.
- Clinics established in Hokitika, Greymouth, Reefton and Franz Josef to see face-to-face referrals and set initial exercise programmes.

Outcomes achieved
- 229 referrals were received and seen in the 2008-2009 year.
- 23% of these referrals were for Maori exceeding the target of 10%.

Funding and expenditure
This programme is funded by SPARC and supported by other sources of revenue within the health promotion budget.

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

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

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

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

Progress 2008-2009
- Contract finalised for PHO to deliver ACC falls prevention programmes in October 2008.
- Tai Chi instructors completed training and first aid courses.
- Tai Chi classes commenced in February 2009 in Hokitika and Greymouth.
- OEP commenced in December 2008.

Outcomes achieved
- 9 participants, Greymouth Tai Chi (11% were Maori)
- 13 participants, Hokitika Tai Chi (77% were Maori)
- 14 participants in OEP programme as at June 30th.

Source of funding
This programme is funded by ACC.

Expenditure
$2,241 incidental expenses (not including human resource).

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, and health professionals.

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

Progress and outcomes
Lactation consultancy:
- 131 new clients (14 Maori, 10 Other Ethnicity; 67 Decile 8-10; 58 rural).

Peer support:
- peer support counsellor training programmes in Hokitika and Reefton: 14 Mum4Mums trained;
- new Maori peer support counsellor training programme delivered (in collaboration with Maori health providers, kuia, and mothers) in Westport, Greymouth and Hokitika: 17 graduates;
- 32 women referred to peer support counsellors, plus many more informal contacts;
- monthly support meetings in Hokitika, Greymouth, Reefton and Westport;
- regular presentations at ante-natal breastfeeding classes;
- a formal evaluation of the peer support counsellor programme found that the programme is running well, and recommended its continuation.

Breastfeeding education sessions:
- 2 one-day workshops for health and community agencies;
- presentations at several other workshop/training events, and the National La Leche League conference;
- sessions at 9 ante-natal classes;
- regular education sessions with midwives and ward staff.

Networking, promotion and advocacy:
- active involvement with many agencies and individuals in the health sector and the wider community, including Maori;
- promotion of World Breastfeeding Week, Early Childhood Expo (Hokitika), and HEHA video conference;
- advocacy on breastfeeding issues with District Councils, CYFS, and TVNZ.

Source of funding
PHO health promotion funding; DHB HEHA funding, and MoH funding.

Expenditure
$67,786

4.4 Maori Heath

Kaiawhina in Buller

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

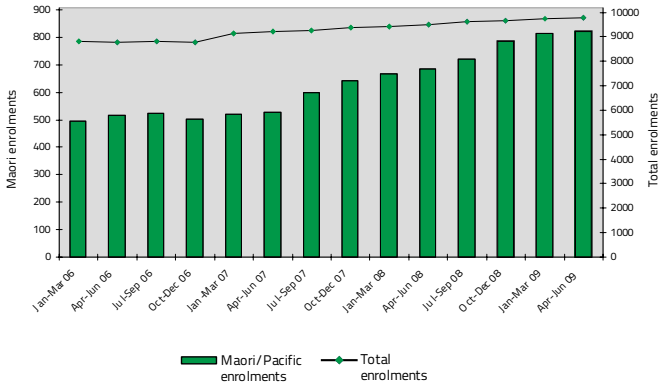
Target group
All Maori living in the Buller region.

Key activities
- to continue to identify and locate Maori not enrolled and missing out on health services/entitlements;
- Kaiawhina to visit homes and other relevant sites, engage, invite and encourage Maori to utilise routine primary health care services;
- increase Maori access to specific health services such as Long Term Conditions enrolment, cardiovascular annual reviews, diabetes annual reviews, cardiovascular risk assessments, immunisations, etc;
- providing support to practice teams at Buller and Reefton Medical Centres, along with rural clinics in the region.

Progress 2008-2009
- The Kaiawhina, in collaboration with general practices in her region has been focusing on promoting the uptake of services to detect and monitor long term conditions. These have included cardiovascular risk assessment, diabetes annual reviews, cardiovascular annual reviews and chronic obstructive airways disease annual reviews then enrolment in the Long Term Conditions Management programme.
- Another key focus has also been in supporting practice teams to identify and locate children for their 11 year old immunisations.
- Further to this, the Kaiawhina has been heavily involved in health promotion activities in the Buller, particularly linked to diabetes, heart health and immunisations.
- The Buller Kaiawhina resigned from her position in May 2009; from this point the position has been on hold pending recommendations from the PHO Clinical Governance Committee and an evaluation of the service.

Outcomes achieved
- Maori enrolments in the Buller region as at June 09 were 95% (as a proportion of the census-derived district Maori population).
- The graph below indicates the trend over time of Maori enrolments in the Buller region (the Kaiawhina started in March 2007).

PHO enrolments in Kawatiri (Buller) District practices

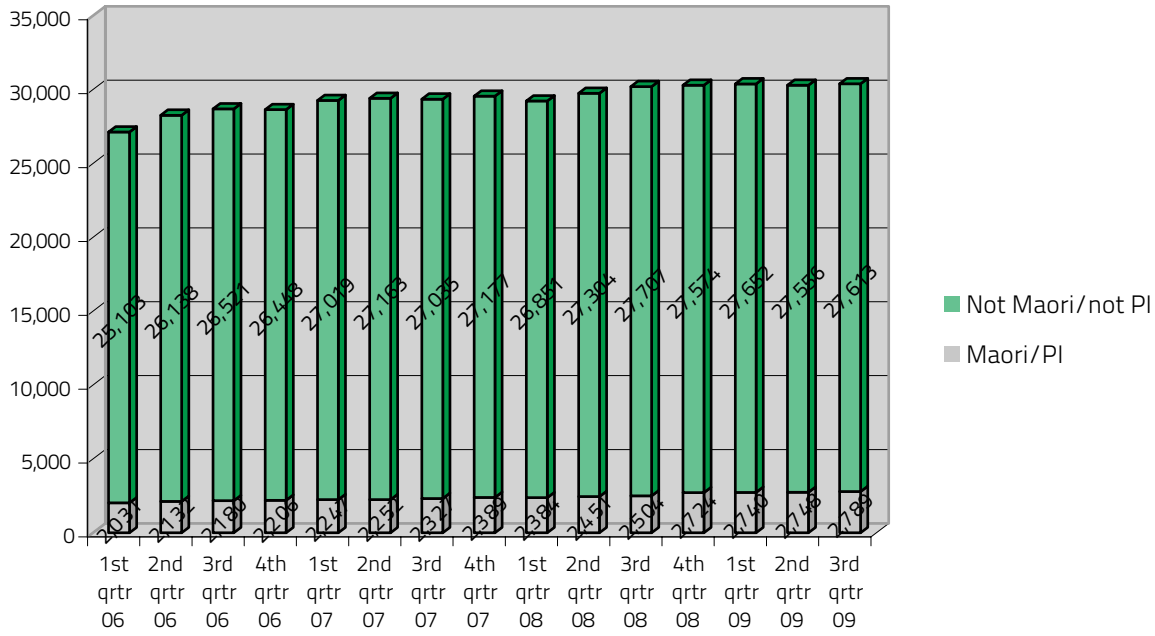


Source of funding
PHO Services to Improve Access funding.

Expenditure
$68,838

Improving Maori Access and Utilisation

Enrolment over time by ethnicity



Over fifteen quarters, enrolments by Maori/PI have grown 37%, while those of non-Maori/non-PI have grown 10%.

Activities and outcomes, additional to the Kaiawhina position

- Four diabetes self-management education courses were contracted out to Rata Te Awhina Trust.
- Clinical programmes are routinely reported-on according to ethnicity - this includes reports to the practices each quarter.
- The Kaihautu position continues, working with Maori who have cancer, and their whanau.
- Oranga Pai (Living Well) hui were held throughout the year in Hokitika, Reefton, and Westport (in conjunction with Children's Day), and in Greymouth in July 2009 - the latter event in particular providing the experience of aspects of Maori culture.
- A one-day workshop by Tim Corbett on social marketing of messages to Maori was attended by all PHO and a range of DHB staff.
- A 3-day Cultural Competence workshop tour of 7 GP practices, by Dr Peter Jansen of Mauri Ora Associates, was attended by 67 practice staff.

Source of funding

A one-off contract of $50,000.

Expenditure

$52,493

4.5 Mental Health Services

Primary Mental Health

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 General Practitioners and Practice Nurses.

Key activities

- triaging of requests from GPTs and assessments for enrolled patients with mild to moderate mental health issues;
- provision of up to six free Brief Intervention Counselling (BIC) sessions for enrolled patients identified with mild to moderate mental health issues who meet criteria, eg, not eligible for other counselling services;
- education and assistance to GPTs in relation to patients with mental health issues;
- facilitation of extended consultations by GPs and PNs with enrolled patients who have mental health issues;
- workshops for primary health practitioners and other relevant groups.

Progress in 2008-2009

- In July 2008, the team was increased from 3 to 4 clinicians with a second psychologist, specializing in working with young people. This enabled the programme to bring down the BIC age criterion from 18 to 14 years, and to work with the parents of children and teenagers. The new psychologist has also been able to offer counselling sessions to those GPT patients who want a Maori provider.On 15th July 2008, at a meeting with representatives from DHB and MOH, the PHO was advised that the PHO Primary Mental Health Programme would be extended until 2010 with fixed term part time administration support.
- The GP Liaison Nurse triaged 414 requests from all GPTs. Where patients met the criteria for BIC, they were then seen by one of the other three clinicians for the counselling sessions. Patients were seen, wherever possible, in their local GPT rooms.
- Evaluation data from the General Health Questionnaire are collected before people enter the BIC sessions, at the last counselling session and at a follow-up session which is held at least six months after the initial sessions. Results continue to be very positive indicating that changes made by the patients have beneficial effects that endure over time.
- The team liaised with government agencies, NGOs, and other community groups, as well as with primary health care services. This year saw the commencement of a facilitation role for the team in bringing together secondary and primary mental health services in order to foster cooperation and work towards reducing gaps in providing services to Coasters with mental health issues.
- Processes were put in place regarding increased access to the programme by Maori, eg, the PHO Kaiawhina based in Westport liaised directly with the team in relation to Maori enrolled patients with mental health issues.
- After two meetings with South Westland primary health staff in June, it was agreed that the Mental Health Programme would extend its support to these practitioners by providing assessments and counselling sessions in the Franz Josef clinic. This had been the only area not covered.
- Claims from GPTs for conducting Extended Consultations on mental health issues totalled 120 for the year.

Educational activities

- presentation on mental health at the three Men's Health hui, one in Franz Josef and two in Greymouth;
- 3 workshops with practice staff;
- presentation to primary health on facilitating groups;
- facilitation of Professional Development included engaging GP Dr Brett Mann, who presented a workshop on mind-body issues, and psychiatrist Dr Sue Luty, who presented a workshop on maternal health and post-natal depression, to primary health care practitioners;
- annual practice visits by the team in October updated GPTs on the programme, especially the lowering of the age criteria, and allowed engagement in two-way discussions on the processes involved and any changes required;
- presentations on the MH Programme were given throughout the year to new GPs and PNs , and similar presentations to other interested groups as required;
- contributed to health hui in Hokitika and Reefton;
- presentation to Southern Regional Mental Health Forum;
- contributed to DHB's Local Workforce Development Plan for the Child and Adolescent Mental Health Service.

Figure 1

Total requests per quarter and total receiving BIC per quarter 2008/09

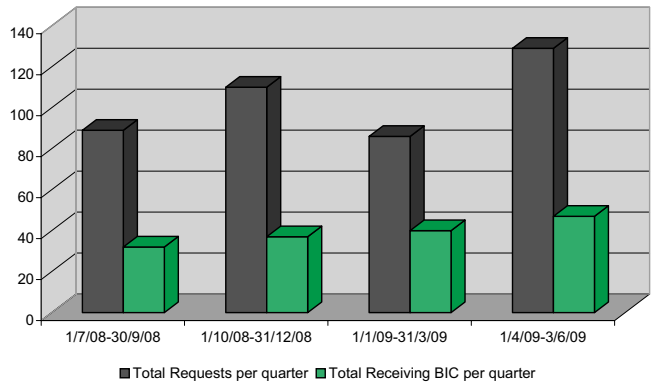
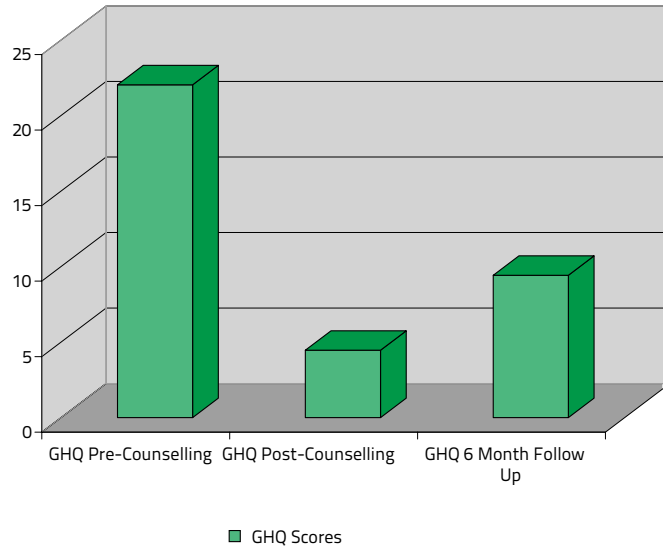


Figure 2

Average GHQ Scores 2008/09



The GHQ12 (General Health Questionnaire) is a recommended MOH evaluation measure and has a possible total score of 36, the higher the score, the higher the psychological distress.

Figure 3

Gender Data 2008/09

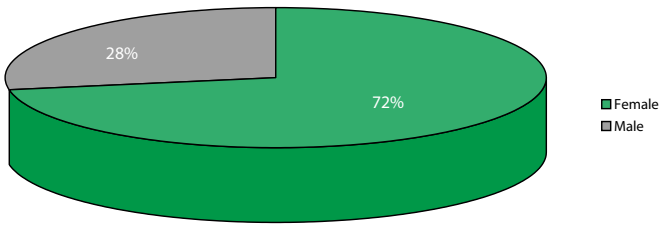


Figure 4

Age Data 2008/09

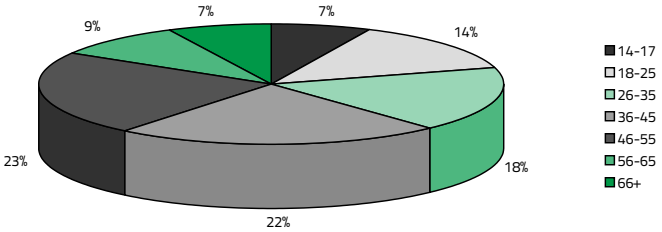


Figure 5

Ethnicity 2008/09

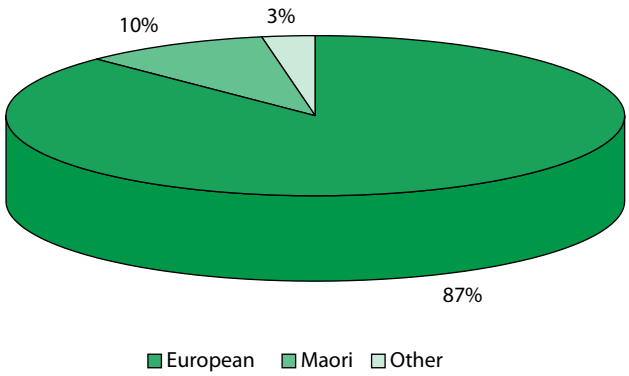
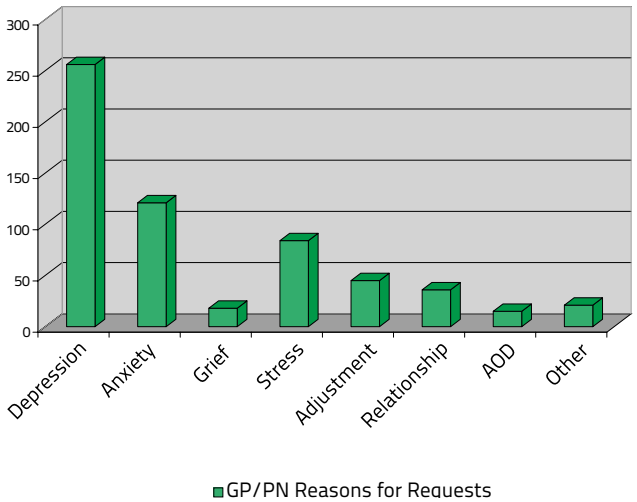


Figure 6

GP/PN Reasons for Requests 2008/09



Mental Health
Ministry of Social Development (MSD)

Aim
To improve the mental health of MSD clients by providing Packages of Care, notably Brief Intervention Counselling (BIC).

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

Key activities
- All MSD clients referred to the Mental Health Team were assessed by the GP Liaison Nurse.
- Clients who met the criteria were offered a Package of Care consisting of six sessions of Brief Intervention Counselling, provided by one of the Mental Health team clinicians. Where indicated, a further two sessions were funded.
- Clients were seen for Brief Intervention Counselling in their local general practice rooms where possible, with a back-up room available at the PHO office in Greymouth.
- Pre and post-BIC measures using the Kessler10 were taken for evaluation purposes.

Progress 2008-2009
- 38 people were referred to the programme during the year, and 26 of these people received counselling.
- Regular meetings were held with MSD staff in Westport and Greymouth in order to clarify processes, provide information on engaging clients who might benefit from the programme, and to give and receive feedback.

Outcomes achieved

Figure 1: MSD Data 2008 - 09

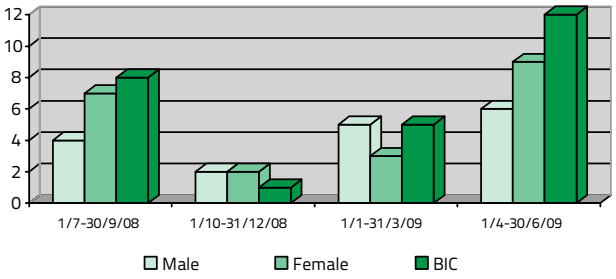


Fig 1 shows the number of beneficiaries (males and females) who participated in the programme this current year, plus the number receiving Brief Intervention Counselling.

The average Kessler10 score for clients prior to counselling was 24, and post-counselling the average score had reduced to 6, indicating a significant reduction in psychological distress and general improvement in mental health.

Source of funding
Ministry of Social Development.

Expenditure
This is included within the total mental health expenditure of $395,778.

4.6 Cancer Services

Cancer Navigation and Support Services

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

Target group
People with cancer and their families/whanau.

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

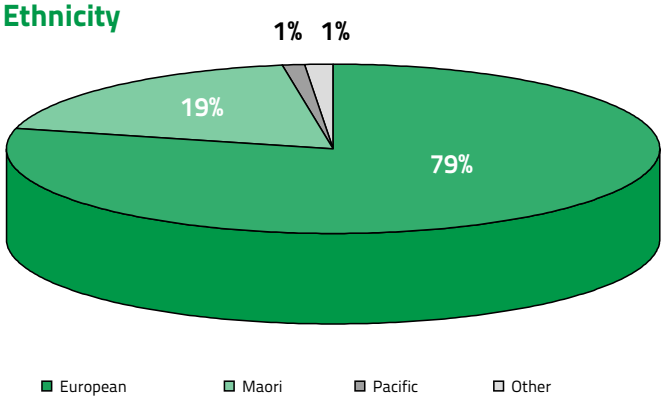
Progress in 2008-2009
- This pilot is being run very successfully and appears to be having a significant impact on people affected by cancer on the West Coast.
- 142 people have entered the service since its inception.

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

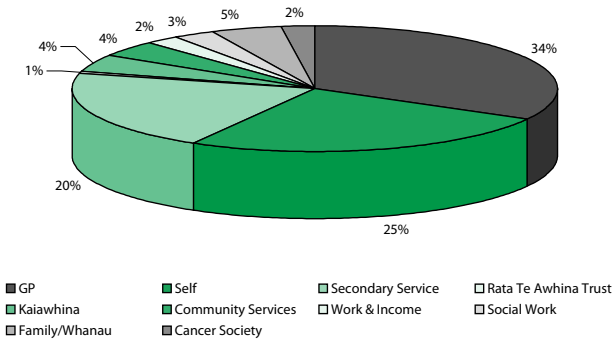
Expenditure
$259,572

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

Ethnicity



Referral



Palliative Care

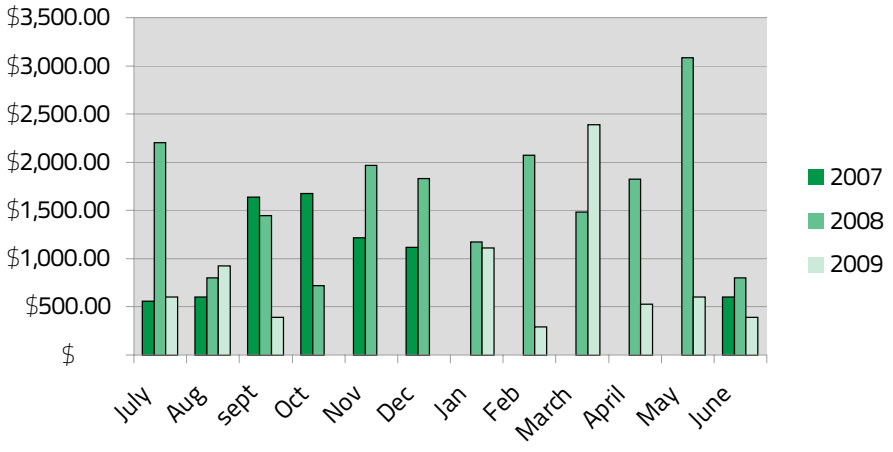
Aim
To relieve any potential financial barriers for patients and their whanau to receive general practice care in the terminal stages of their illnesses.

Target group
Patients with a terminal illness.

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

Progress in 2008-2009
- This programme covers the costs of visits to the general practice, home visits, and some part charges for medications used in a palliative setting for enrolled palliative care patients.
- Utilization of the programme has been slightly lower this financial year compared with 07-08.

Outcomes achieved



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

Expenditure
$14,035

5. Quality Improvement and Professional Development

5.1 PHO Performance Programme

Aim
To achieve nationally agreed quality indicators.

Target group
GP Practices and the PHO.

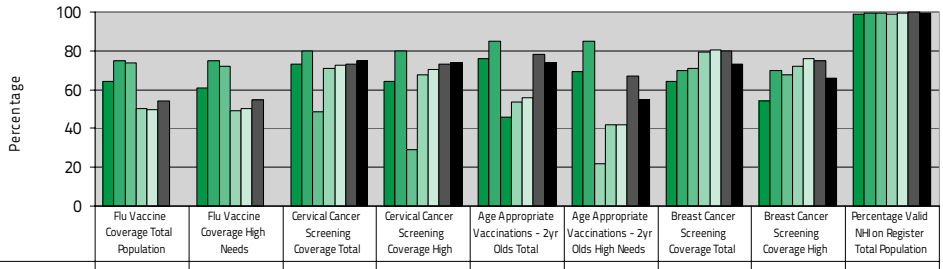
Key activities
- Each practice has an established Quality Improvement Team which manages their programme.
- A Quality Improvement plan is developed by each practice which guides the practice's efforts for the year. This plan is submitted to the Clinical Governance Committee annually. This process fulfills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

Outcomes achieved
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 Primary Care on the West Coast. These results could not be achieved without administrators, nurses and doctors working together.

The development of the PHO Performance Programme Dashboard by DHBNZ has been well received. The accompanying table and graphs illustrate what has been achieved.

The only area we fall well behind the National average is in our Immunisation rate. There are significant groupings in our communities who are opposed to immunisation which makes a significant impact on being able to achieve these targets. The WCPHO is grappling with this issue.

Indicators that measure Preventive Health activities



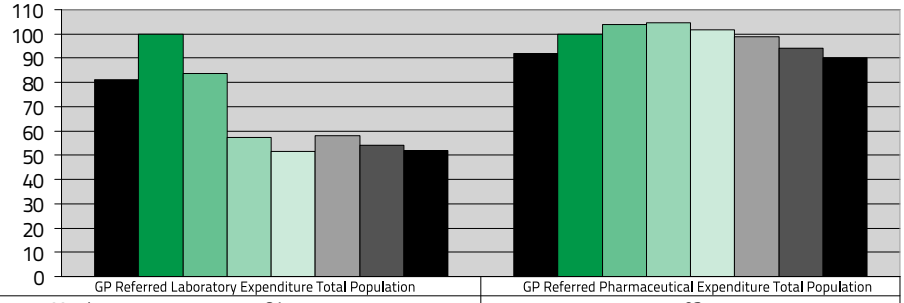
	Flu Vaccine Coverage Total Population	Flu Vaccine Coverage High Needs	Cervical Cancer Screening Coverage Total	Cervical Cancer Screening Coverage High	Age Appropriate Vaccinations - 2yr Olds Total	Age Appropriate Vaccinations - 2yr Olds High Needs	Breast Cancer Screening Coverage Total	Breast Cancer Screening Coverage High	Percentage Valid NHI on Register Total Population
National Average March 2009	64	61	73	64	76	69	64	54	99.00
Programme Goal	75	75	80	80	85	85	70	70	99.50
Baseline Value - Sept 2005	74	72	48	29	46	22	71	68	99.38
30 September 2006	50	49	71	68	54	42	79	72	99.15
30 September 2007	50	50	73	70	56	42	80	76	99.70
30 September 2008	54	55	73	73	78	67	80	75	99.79
30 March 2009			75	74	74	55	73	66	99.62

Preventative Indicators Progress Report 2008-2009

These indicators reflect our practices' engagement with their local enrolled populations. There was a slight improvement in the Influenza immunisation rate last year; however, this is an area which continues to challenge us.

Indicators that measure Referred Services and Utilisation

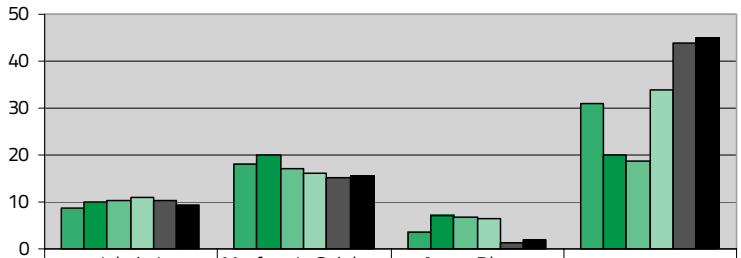
Progress Report Referred Services and Utilisation 2005-2009



	GP Referred Laboratory Expenditure Total Population	GP Referred Pharmaceutical Expenditure Total Population
National Average March 2009	81	92
Programme Goal	100	100
Baseline Value - Sept 2005	84	104
30 September 2006	57	105
30 September 2007	51	102
30 March 2008	58	99
30 September 2008	54	94
30 March 2009	52	90

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

Clinical Indicators



	Inhaled Corticosteroid Dose/100	Metformin:Sulphonylureas Total Population	Acute Phase Response Total Population	Thyroid Function Total Population
National Average March 2009	9	18	3	31
Programme Goal	10	20	7	20
Baseline Value - Sept 2005	10	17	7	19
30 September 2006	11	16	6	34
30 September 2007	10	15	1	44
30 September 2008	9	16	2	45

We have achieved all the National Targets except with regard to reducing the prescribing of Sulphonylureas for the treatment of Diabetes.

Source of funding

Funded as per the national funding formula for PHO performance programmes.

Expenditure

$65,491

5.2 Professional and Practice and Development

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

Target group
All members of the general practice teams.

Key activities
- Professional development activities include local workshops/study days, local video-linked evening education sessions (coverage from Hokitika to Westport), and funded access to conferences and training opportunities mostly beyond the West Coast.
- Practice development activities centre on assisting practices with the RNZCGP Cornerstone practice accreditation programme.

Progress and outcomes 2008-2009

Local study days
- PHO Day (46 attended)
- Practice Administration Day (21)
- Practice Nurse study day on women's health (17)
- 2 long-term condition management workshops (64), and a COPD study day (25)
- Flinders refresher course (7)
- Cultural Competence training session at each of the practices, for all practice staff.

Continuing Medical Education (evening sessions)
- Dr Anna Dyzel is contracted to co-ordinate the CME programme and arrange the local medical education sessions, with oversight from the Professional and Practice Development sub-committee and feedback from a CME needs survey.
- 6 sessions were presented, with a total of 40 GP attendances, 45 nurse attendances, and 14 'other occupation' attendances. Topics included spirometry, post-natal depression, routine ante-natal HIV testing, palliative care, assessment of the unwell child, and best-practice software for performance management.

Conference/Course leave funded from quarterly allocations to practices
- There were 15 funding grants for GPs, 56 for nurses, and 8 for practice administration/management, to attend 38 educational events.

Cornerstone practice accreditation
- Over this period, 3 practices have been working towards accreditation, and 1 practice towards re-certification.
- 3 tutorial sessions on the Cornerstone process were provided by a practice QI consultant.

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

Expenditure
$65,491

5.3 Rural Bonus

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
- two GP registrar scholarships available, to attract young GPs to the Coast;
- personal interviews with health professionals who are new to the Coast, to develop practical guidelines that will enhance recruitment and retention;
- ancillary support funding to practices (in extraordinary situations) for continuity of medical services;
- further work on the implementation of the after-hours plan with the DHB;
- team building and individual mentoring sessions for practice staff, from the PHO primary mental health team.

Progress and outcomes, 2008-2009
- two GP registrar scholarships issued;
- Rural Workforce Retention Guidelines report completed, and discussed with practice managers;
- ancillary support funding accessed once this financial year;
- after-hours survey carried out with practices (on behalf of the Clinical Governance Committee);
- several meetings on the after-hours plan;
- 'Healthline' presentation to key stakeholders (DHB, practices, PHO), hosted by the PHO;
- PHO support for further work by DHB on use of Standing Orders to relieve GP workload;
- several team-building workshops for practices, and individual mentoring sessions.

Source of funding
Rural workforce retention funding from Rural Premiums.

Expenditure
$37,341

Reasonable Rostering, and Rural Bonus

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

Aim
These are flexible resources 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 PHO pays the bulk of this funding to eligible practices and service providers.

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

Source of funding
Reasonable Rostering and Rural Bonus funding.

Expenditure
$269,100

Financial Statements

West Coast Primary Health Organisation Trust
For the year ended 30 June 2009

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West Coast Primary Health Organisation Trust

Directory

As at 30 June 2009

Principal Business:	Primary Health Organisation
Address:	PO Box 544 163 Mackay Street Greymouth
Trustees:	Trustees at 30 June 2008 John Boyes (appointed 28/08/08) Anna Dyzel Maureen Pugh Tim Rochford Rosalie Sampson Tamai Sinclair Richard Wallace Tony Coll Helena Evers (appointed 28/08/08)
Independent Chairperson:	John Ayling
Auditors:	WHK Taylors Dunedin
Solicitors:	Hannan & Seddon Greymouth
Bank:	Westpac Bank

West Coast Primary Health Organisation Trust

Statement of Financial Performance

For the year ended 30 June 2009

	Consolidated 2009 $	Consolidated 2008 $	Parent 2009 $	Parent 2008 $
INCOME				
Revenue	7,837,505	6,672,952	7,837,505	6,672,952
Interest Received	57,085	59,469	57,085	59,469
Sundry Income	49,586	28,454	49,586	28,454
TOTAL OPERATING INCOME	7,944,176	6,760,875	7,944,176	6,760,875
OPERATING EXPENSES				
Audit Fee	6,019	4,224	6,019	4,224
Bad Debts	204	-	204	-
Bank Fees	1,734	947	1,234	947
Contract Payments	6,263,904	5,412,688	6,263,904	5,412,688
Insurance	5,835	7,093	5,835	7,093
Leases	104,409	78,708	104,409	78,708
Other Expenses	279,141	222,461	278,141	222,461
Telecommunications	29,492	24,702	29,492	24,702
Salaries & Wages	988,047	705,305	988,047	705,305
Trustee Meeting Fees	64,577	51,564	64,577	51,564
Trustee Reimbursements	1,941	14,949	1,941	14,949
Depreciation	53,085	37,591	52,985	37,591
	7,798,388	6,560,232	7,796,788	6,560,232
NET SURPLUS FOR THE YEAR	145,788	200,643	147,388	200,643

West Coast Primary Health Organisation Trust

Statement of Movements in Equity

For the year ended 30 June 2009

	Consolidated 2009 $	Consolidated 2008 $	Parent 2009 $	Parent 2008 $
Net Surplus For The Year	145,788	200,643	147,388	200,643
TOTAL RECOGNISED REVENUE AND EXPENSES	145,788	200,643	147,388	200,643
Equity at Beginning of Year	716,326	515,683	716,326	515,683
EQUITY AT THE END OF THE YEAR	862,114	716,326	863,714	716,326

West Coast Primary Health Organisation Trust

Statement of Financial Position

As at 30 June 2009

	Note	Consolidated 2009 $	Consolidated 2008 $	Parent 2009 $	Parent 2008 $
EQUITY		**862,114**	**716,326**	**863,714**	**716,326**
Represented By:					
CURRENT ASSETS					
Westpac Bank		262,272	138,926	133,987	138,926
Westpac Bank Saver		1,097,669	742,044	1,097,669	742,044
Accounts Receivable		577,628	320,905	577,628	320,905
Petty Cash		445	-	445	-
Inventory		-	-	-	-
Loan Greymouth Family Health Centre Ltd		-	-	170,000	-
Prepayments		5,100	3,853	4,020	3,853
TOTAL CURRENT ASSETS		1,943,114	1,205,728	1,983,749	1,205,728
NON-CURRENT ASSETS					
Property, Plant & Equipment	4	207,821	178,492	204,921	178,492
Shares in Greymouth Family Health Centre Ltd		-		5,000	-
Goodwill		41,000	-	-	-
TOTAL NON-CURRENT ASSETS		248,821	178,492	209,921	178,492
TOTAL ASSETS		**2,191,935**	**1,384,220**	**2,193,670**	**1,384,220**
CURRENT LIABILITIES					
Trade creditors		554,051	164,883	554,051	164,883
GST Payable		21,621	62,971	21,756	62,971
Reserved Funding		707,285	396,376	707,285	396,376
Employee Entitlements		46,864	43,664	46,864	43,664
TOTAL CURRENT LIABILITIES		**1,329,821**	**667,894**	**1,329,956**	**667,894**
NET ASSETS		**862,114**	**716,326**	**863,714**	**716,326**

For and on behalf of the Trustees

Trustee

Date 2/10/2009.

Trustee

Date 2-10-09

Notes to the Financial Statements

For the year ended 30 June 2009

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 as GST exclusive financial statements have been prepared.

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

RECEIVABLES

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

INCOME TAX

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

GOODS AND SERVICES TAX

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

INVENTORY

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

GOODWILL

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

REVENUE RECOGNITION

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

PROPERTY, PLANT & EQUIPMENT

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

DEPRECIATION

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

The rates used are:

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

BASIS OF CONSOLIDATION

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

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

CHANGES IN ACCOUNTING POLICIES

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

2 RELATED PARTIES

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

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

- Richard Wallace is a part-time employee of the PHO, providing cultural support on contract.

3 CAPITAL COMMITMENTS AND CONTINGENT LIABILITIES

The PHO has contracted to purchase assets valued at nil (2008: NIL) as at balance date.

There were no contingent liabilities at the balance date (2008: NIL).

4 PROPERTY, PLANT & EQUIPMENT

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

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

2008	Cost	Depn	Accum Depn	2008 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

5 NON-CANCELLABLE OPERATING LEASE COMMITMENTS

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

	2009	2008
Current Portion	134,005	96,651
Non-Current Portion	86,447	177,079
	220,452	273,730

6 BANK SECURITY

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

WHK Taylors

Audit Report

To the Trustees 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 and financial position of the Trust and Group as at 30 June 2009. This information is stated in accordance with the accounting policies set out on pages 5 and 6.

Trustees Responsibilities

The Trustees are responsible for the preparation of financial statements which fairly reflect the financial position of the Trust and Group as at 30 June 2009 and the results of their operations for the year ended on that date.

Auditors' Responsibilities

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

Basis of Opinion

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

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

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

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

Unqualified Opinion

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 and Group as at 30 June 2009 and the results of their operations for the year ended on that date.

Our audit was completed on 2 October 2009 and our unqualified opinion is expressed as at that date.

WHK Taylors
Dunedin

Karamea Health Clinic
Waverly St, Karamea. Ph (03) 782 6710

Buller Medical Services
45 Derby St, Westport Ph (03) 788 8230
Clinic at Ngakawau Ph (03) 788 5062

Reefton Medical Centre
103 Shiel St, Reefton Ph (03) 732 8605

Greymouth Family Health Centre
26 Mackay St, Greymouth Ph (03) 768 5585

Greymouth Medical Centre
153 Tainui St, Greymouth Ph (03) 768 0581

High St Medical Centre
135 High St, Greymouth Ph (03) 768 5942

Westland Medical Centre
54A Sewell St, Hokitika Ph (03) 755 8180

South Westland Area Practice
Whataroa Ph (03) 756 1080

Clinics at:
Harihari Ph (03) 753 3008
Franz Josef Ph (03) 752 0700
Fox Glacier Ph (03) 751 0836
Haast Ph (03) 750 0800

WEST COAST
Te Tai o Poutini
Primary Health Organisation

West Coast Primary Health Organisation
PO Box 544, Top Floor, 163 Mackay Street, Greymouth
Telephone: (03) 768 6182
www.westcoastpho.org.nz