Annual Report 2015

Cosine
Primary Care Network

Report for the period 1 July 2014– 30 June 2015

Vision

Our vision is to be recognised by the Ministry of Health, the local District Health Boards and the relevant communities as one of New Zealand's most innovative and effective primary care networks in terms of delivering better, sooner, more convenient Primary Health Care to its enrolled population.

Mission Statement

Cosine Primary Care Network's (Cosine) mission is to be an independent, high performing and innovative organisation providing high quality primary health care services to our enrolled population.

Population

Cosine has an enrolled population of 33,609 patients. Of these 6% are Maori, 3% are Pacific and 12% Asian.

15% are identified as High Needs.[1]

[1] High Need Groups are defined as groups of persons who are Maori, Pacific and/or person residing in New Zealand Deprivation Index deciles 9 &10 areas. (Capital & Coast DHB/ KPHO Contract Version 18.0)

EXECUTIVE SUMMARY

During 2014-15 Cosine Primary Care Network has improved on the high performance achieved in the preceding years through the continued efforts of both Karori Medical Centre and Ropata Medical Centre.

Cosine has also increased its profile through extensive participation and representation at various forums within the health arena, at local, regional and national levels. *(See appendix 1).*

There have been some significant changes in following on from the appointment of Jonathan Coleman as the Minister of Health in October 2014. His Letter of Expectations[2] released in December 2014 set out the following

- That DHBs are expected to operate within budget and improve year on year financial performance
- And provide Strong clinical leadership
- There must be increasing Integration between Primary and Secondary care- for better management of long-term conditions, mental health, an aging population and patients in general
- And better performance against the National Health targets- DHBs are expected to drive improvements
- Health agencies are expected to work in across sectors with education, justice and social services to tackle the key drivers of morbidity, for example obesity and children living in material hardship.

There has been a financial impact on the primary care sector through a reduction in funding for contracted services, for example sexual health. This has meant that free sexual health consultations are now offered to those under 20 years rather than under 23 years.

Two Ministerial reviews are underway, the outcomes of which will have an impact on primary care;

1. A review of the refreshed New Zealand Health Strategy. Draft documents have been circulated for consultation and responses are expected by the 4th of December. [3]

[2] http://nsfl.health.govt.nz/dhb-planning-package/201516-planning-package/minister%E2%80%99s-letter-expectations-201516

2. A primary care working group have been tasked with a review of general practice sustainability, including options for change and how to enhance the breadth of services provided in primary care settings.

Legislative changes impacting on Cosine include the Vulnerable Children Act 2014 which requires employers to undertake worker safety checks for all employees. We are also closely monitoring the information available in regard to the Health and Safety Act Reform Bill. This Bill strengthens existing requirements for worker engagement and participation in work health and safety matters. The proposed changes to the act will require a significant increase in governance, compliance and training requirements for workplaces and the workforce. [4]

An inclusion in the V3 Agreement (1 Jul 2015) is the requirement to achieve a Foundation Standard. This represents what is considered to be the minimum legal, professional and regulatory requirements for general practice. PHOs will be required to demonstrate that their general practices comply with the Foundation Standard by 1 July 2016. As both practices are accredited through the RNZGP Cornerstone programme, Cosine is considered to have achieved the Foundation standard requirement.

Improving access to healthcare is an important driver for both practices. The Zero fees for Under 6s' initiative was extended to include those under 13 years on 1 July 2015. The launch was held at Karori Medical Centre and attended by the Health Minister and the Prime Minister, the Honourable John Key. Both practices now offer free care to their enrolled patients aged less than 13 years of age.[5]

During 2014-15 the practices have encouraged patients to use the patient portal -Manage My Health. Patient portals give people convenient and secure electronic access to their health information, increasing their ability to manage their own health care and improving their access to services at a time that is convenient to them[6]

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[3] http://www.health.govt.nz/system/files/documents/publications/update-nz-health-strategy-consultation-draft-part-i-future-direction-oct15.pdf

[4] http://www.business.govt.nz/worksafe/about/reform/reform-bill-key-changes

[5] http://www.health.govt.nz/your-health/services-and-support/health-care-services/visiting-doctor/zero-fee-doctors-visits-children-aged-under-13

[6] http://www.beehive.govt.nz/release/patients-take-more-control-their-own-health

Governance

Cosine is a not-for-profit charitable trust governed by a Board of Trustees. The Trust Board consists of eight Trustees appointed to represent the community, providers and local iwi.

The Trustees are

- An independent Chair - Murray Gough
- Two community/consumer representatives - Margaret de Joux (Karori Medical Centre) and Nolaine Coombes (Ropata Medical Centre)
- An Iwi representative - Rawiri Evans (Te Ati Awa)
- Four provider representatives - Drs Jeff Lowe and Peter Moodie (Karori Medical Centre) and Drs Chris Masters and Don Barrett (Ropata Medical Centre)

Progress against the Business Plan to June 2015

The following seven objectives were the focus for the Business Plan 2014-15

1. The provider practices of Cosine will maintain their status as high-achieving, innovative practices. This will be demonstrated by ongoing success in relevant clinical performance measures.
2. The provider practices of Cosine are held up as exemplars of Primary Health Care.
3. The sharing of innovative ideas will occur across the Primary Care Network and the health sector.
4. To engage with the local DHBs in the delivery of new programmes and models of care.
5. To work within sustainable funding
6. To achieve targets in order to receive 100% of the available funding e.g. PPP, CarePlus
7. To attract funding for innovative pilot projects

Reporting on progress around these aims is provided annually to Capital and Coast DHB.

Activity

1. *Success in the relevant clinical performance measures.*

Cosine has exceeded the high performance of previous years. A letter from Virginia Hope, Chairman of CCDHB and Hutt Valley DHBs, passed on congratulations from the Health Minister on Cosine's achievement of all the primary care and iPIF targets for Q4 2014-15.

This achievement is arrived at through significant and on-going effort from the provider practices.

2. *Exemplars of Primary Health Care*

Cosine consistently achieves high rates that are above the national average. In addition, the practices are proactive in seeking innovative ways of providing primary care services. Examples are RMC's minor surgery service and KMC's use of ultrasound in general practice.

3. *Sharing of Innovative ideas*

Regular meetings of the practice staff facilitate the flow of ideas and encourage continuous quality improvement. Leaders from both practices are members of local and national forums exploring new ways to deliver primary health care within the available funding.

4. *Engaging with DHBs in the delivery of new programmes*

The clinical leads have established roles within Hutt INC and the ICC. Examples are the Diabetes Care Improvement Plan and Nurse Practice Partnership which evolved from the ICC Long Term Conditions group and the Health Pathways project. Both practices are exploring the Health Care Home Model of Care.

5. *To work within sustainable funding*

A key objective for Cosine is that the provider practices deliver core services from on-going funding in order to mitigate risk around staffing and service delivery. All activities and initiatives are developed and managed with this objective in mind. In this reporting period the practices have had funding for contracted services reduced and this will impact on the both the service delivered and the ability of the practices to maintain a high standard of care.

6. *To achieve targets in order to receive 100% of the available funding*

The targets for this period were increased significantly from the previous period in order to meet CCDHB's requirement to bring targets in to line with the MOH expectations. This resulted in less progress towards the targets and reduced payments to Cosine, despite overall continued improvement in the percentages achieved.

7. *To attract funding for innovative pilot projects*

To date there has been no progress on this aim.

iPIF and Health Targets

The Minister of Health, Hon Dr Jonathan Coleman, confirmed no new measures have been added to the IPIF programme for 2015/16.

The focus continues on the current five IPIF measures:

- more heart and diabetes checks
- better help for smokers to quit
- increased immunisation at 8 months
- increased immunisation at 2 years
- Increased cervical screening.

Hon Dr Coleman is interested in moving faster towards outcome measurement at a national level with a system-wide view of performance, as well as an ability to measure outcomes for each of the component parts. The Minister has asked the Ministry to engage with the sector to develop five to seven national health outcome measures that are meaningful and measurable, and which can be influenced by the frontline clinicians. This work is currently underway. An example of how this may look is the target 'Caries Free at 5 years.

The outcomes of the refresh of the *New Zealand Health Strategy* and the funding, and capability and capacity reviews will also influence these measures and provide a direction for IPIF going forward (McLean, 2015)

PHO WEIGHTED RANKING TO 30 JUNE 2015

COSINE PERFORMANCE ACROSS THE THREE MOH HEALTH TARGETS				
	1 Apr - 30 Jun 15	1 Jan - 31 Mar 15	1 Oct - 31 Dec 14	1 Jul to 30 Sep 14
Health Target	**Q4**	**Q3**	**Q2**	**Q1**
Increased Immunisation	**1** (98%)	**1** (99%)	**1** (100%)	**1**
Better help for Smokers to Quit	**13** (93%)	**12** (94%)	**13** (95%)	**22**
More Heart and Diabetes Checks	**18** (90%)	**22** (88%)	**21** (87%)	**23**

Brief Advice: 12 PHOs were above 93% and 23 below. Results ranged from 70% (Ora Toa) to 122% (Nga Mataapuna Oranga)

Heart and Diabetes: 6 other PHOs also got 90%, 15 were above 90% and 15 were below 90%. Results ranged from 81% (Nga Mataapuna Oranga) to 93% (Ngati Porou Hauora)

Please see attachment 2 for more information on where Cosine sits in regard to other PHOs.

ACHIEVEMENTS IN 2014-15

Karori Medical Centre

1. **Diabetes Model of Care**

We have been particularly pleased with the Diabetes Care Improvement Plan and Nurse Practice Partnership which delivers integrated care to our patients. The enhanced level of care has improved outcomes for our patients through care delivered closer to home and increased skill in the nursing team.

2. **Enrolments in Manage My Health- the patient portal.**

Enrolment levels in the patient portal are amongst the best nationally. This has been achieved through an All of Practice approach, having a clinical champion and an administrator dedicated to the task. As at 1 July 2015 40% of the eligible population were registered to the portal.

3. **Continued High Performance in Primary Health Targets and iPIF Measures.**

Cosine practices have maintained a consistently high level of performance across the health targets. Continuous improvement at this level is achieved through the efforts of the whole practice, with clinical champions taking the lead for specific areas.

4. **Long Term Conditions- Flexible funding**

A change from the more structured Care Plus funding model to a flexible long term conditions funding pool has provided clinicians with the opportunity to enable extended consultation for patients with complex needs, high risk conditions or requiring palliative care.

5. **Services to Improve Access Initiatives**

KMC has maintained support to high health needs patients through a range of SIA initiatives including;

- **Healthy Families Initiative**

  The number of patients enrolled in the initiative has remained steady over many years and is currently 108 (30 families). Consultations and prescriptions are free for these families.

- The low cost prescription initiative is a collaborative venture with eight Wellington Pharmacies which provides a service for those people who find cost a barrier to accessing medication.

- The **transport** initiative is a service available to high health needs patients attending hospital appointments or Primary Care appointments. It is closely monitored by the finance subcommittee and where possible patients are linked in with existing transport

options e.g. Total Mobility. The demand for this service is unchanged from the previous reporting period.

- **Hospital Discharge Initiative**

  Supports patients who have had a consultation with their GP (paid for by the PHO through SIA funding) following an inpatient stay at Wellington Public Hospital. This service is particularly useful for patients requiring a medication review following changes to their medication made while they were in hospital.

Ropata Medical Centre

1. **Continued High Performance in Primary Health Targets and iPIF Measures**

RMC have continued to highly perform in Primary Health Targets and iPIF measures, together with KMC achieving all targets as Cosine PHO.

RMC have particularly concentrated on smoking targets and CVRA, achieving targets with some specific input from a Healthcare Assistant for smoking cessation advice and a Nurse for CVRA, carrying out virtual assessments.

2. **Providing a Hutt Valley Wide IV Cellulitis Service**

RMC have provided an IV Cellulitis Service to all GP practices in the Hutt Valley, covering the hours up until the After Hours service can take over the provision of this service.

3. **Providing a Hutt Valley Wide Minor Surgery Service**

Dr Sonja Bodley provides a minor surgery service, offering the removal of more complex skin lesions. This service can be accessed by self-referral from any person living in the Hutt Valley or by a referral from their GP.

4. **Achievement of Southern Cross Accreditation for the Facilities at RMC**

In May 2015, RMC were audited by Southern Cross, this was based on the facility, processes and policies. RMC achieved accreditation status and accredited providers can now provide services for minor surgery procedures from RMC facilities.

5. **Flexibility of Care Plus and SIA Funding**

RMC have reviewed SIA and Care Plus funding use in the Practice and have set up an account in MEDTECH where staff can utilise this funding for those most in need patients. The funding is now used flexibly for nurse or GP appointments, tests and sometimes transport.

6. Pre-Diabetes Project

RMC have utilised under used health promotion funding to offer all patients who have a test result in the range of pre-diabetes a free nurse appointment.

The patient is asked to keep a food and exercise diary and to bring this to their appointment, where education is provided by the nurse and the consequences of developing diabetes is explained to the patient.

RMC hope that this project will support the reduction in the number of patients going on to develop diabetes.

7. Manage my Health

RMC have registered 772 patients this year on the Manage my Health patient portal and are continuing to promote its use within the practice and to patients. The waiting room now has a chrome book which patients can use to activate their account whilst they are in the Practice

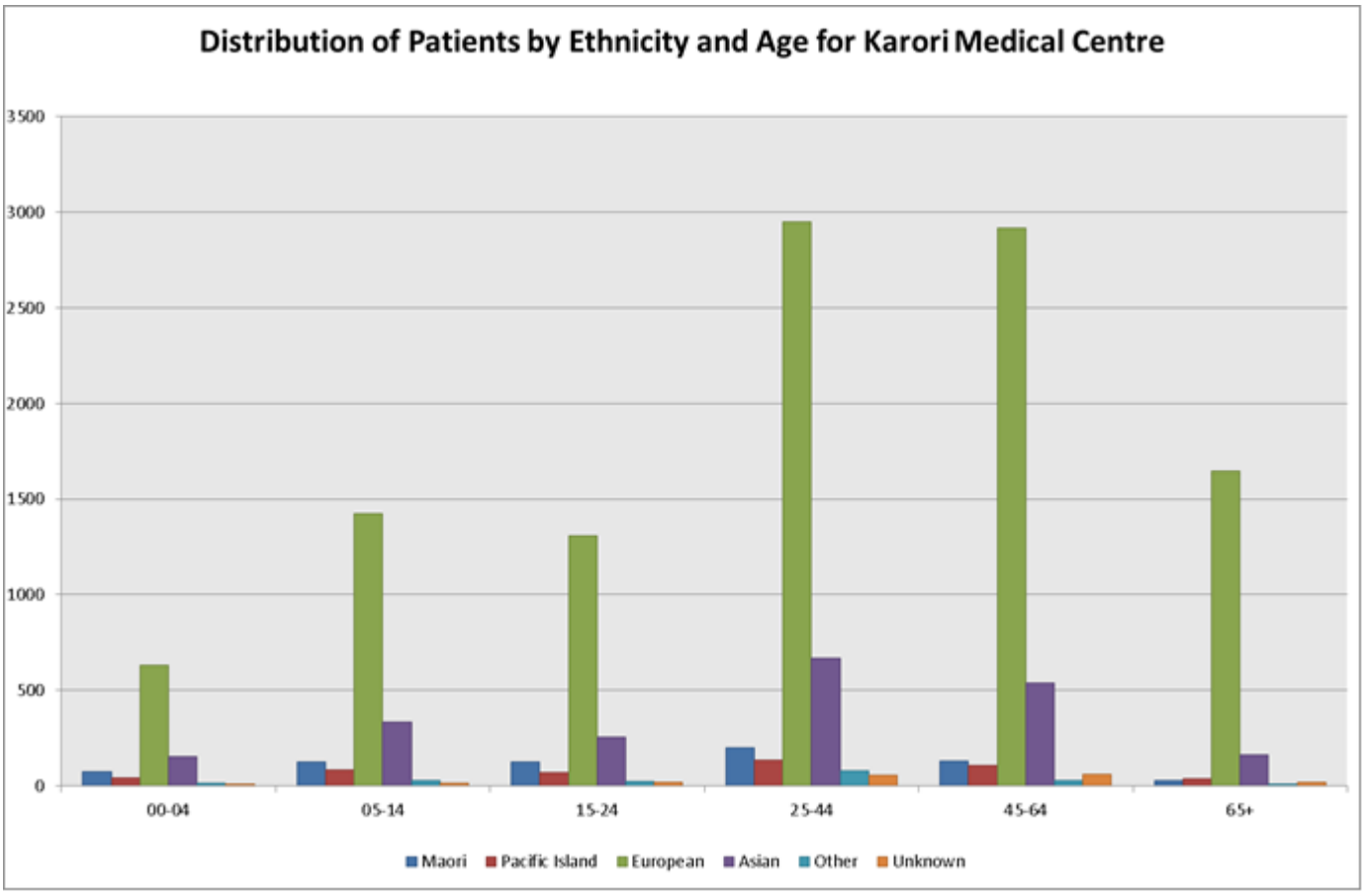
LOOKING FORWARD 2015-16

Karori Medical Centre
SIA & HP Plan
2015-16

Karori Medical Centre has 14,517 enrolled patients (1st July 2015). Of these 9% are identified as High Needs. Patients are residents of Karori, Wellington and its environs.

KMC's patient population consists of:

- 5% Maori
- 3% Pacific
- 1% Quintile 5 Non Maori or Pacific
- 12% Asian



Summary

This Services to Improve Access and Health Promotion plan covers the period from 1 July 2015 to 30 June 2016

Key Achievements 2014/15

1. Successful implementation and delivery of the Diabetes Care Improvement Plan
2. Participation in the Diabetes Nurse Practice Partnership
3. Continued support of families and whanau through initiatives such as Healthy Families, Low Cost Prescriptions and the Transport Initiative.
4. Improving access to services for patients through their enrolment in Manage My Health- the patient portal.

Priorities to 2016

We will

- Increase the number of patients enrolled in Manage My Health in order to facilitate easy access to services.
- Contribute to local, regional and national groups to improve integration of health services.
- Contribute to local and city wide health, welfare, emergency management and exercise promotion activities and initiatives

Focus for 2015-16

1. To maintain and where possible improve utilisation in our SIA initiatives
2. To work within the funding provided
3. To prioritise services to the High Health Needs group.
4. To focus on Long Term Conditions
5. To support health campaign pilot projects
6. To align services to meeting those of the health targets that relate to Primary Care

Services to Improve Access Initiatives

Initiative	Service Delivery
Healthy families Initiative	This program supports patients where cost is a barrier to accessing timely medical care. Patients are identified by an outside agency e.g. a pharmacy, well child nurse, church group. The PHO funds GP consultations.
Hospital discharge Initiative	This service is offered to patients following an inpatient stay in hospital and aims to address medication reconciliation in a timely manner and also ensure that patients have all the services in place that they may need when they return home.
Emergency Department Attendances	This is a component of the hospital discharge initiative. The service is offered to patients who attended the Emergency Department. The aim is to treat patients with chronic conditions e.g. asthma, at their primary health care practice, therefore reducing the burden on the Emergency Department.
Interpreting Services	In order to assist those who 1) have English as a second language e.g. refugees & migrants and 2) to assist those with impaired hearing.
Low cost prescriptions	This service is offered to patients identified by a Pharmacy, GP, Nurse or outside agency as finding cost a barrier to collecting medication in a timely manner.
Transport Initiative	To assist patients to attend scheduled hospital appointments e.g. renal clinic, cardiology. This ensures that the patient is assisted to attend routinely and is therefore less likely to present acutely to the hospital services.

Health Promotion Initiatives

Initiative	Service Delivery
Best Practice Services	Used as a tool in the delivery of Cardiovascular risk assessments, Diabetes Annual 'Get Checked' reviews, INR monitoring, Kessler 10 assessments.
Dietitian(Education)	A six week programme aimed at improving outcomes for a particular group e.g. Diabetics. Not currently running however we are looking for suitable people to facilitate a group and will have a group underway in Q4.
Health campaigns	Projects dedicated to improving rates achieved for cervical screening, flu vaccinations, childhood vaccinations, cardiovascular risk assessments, Diabetes Get Checked Annual reviews and continuous quality improvement in Clinical Performance Indicators. KMC adopts a 'whole of practice' approach to health campaigns.

Increasing Activity	Providing Increasing Activity vouchers at Karori Medical Centre. Linking with the other Wellington PHOs and Wellington City council providing free or subsidised access to activities at the pools and recreation centres. Targeting, in particular, CarePlus patients and those with high health needs. Linking patients in with the WCC Leisure Card. Linking patients in with existing walking groups and exercise classes.
Liaison	Supporting collaboration and networking with other CCDHB PHOs
Maori Health	To undertake a review of Te Timatanga, the Maori health Plan of Cosine PHO (Karori), and complete an analysis of Maori and other high health enrolled patients.
Training & Education	To support those delivering the contractual requirements of Cosine PHO (Karori) to undertake appropriate training. E.g. e learning for diabetes management
Youth Health	Free consultations and prescriptions for young people aged 15- 19 years identified by an outside agency e.g. Karori Youth Worker, local church youth groups.

Actions	**Targets**
Deliver a health campaigns to • increase awareness of the benefits of flu vaccination • improve cervical screening rates (high needs group) • improve Diabetes annual check rates (high needs group) • improve cardiovascular risk assessment rates (high needs group)	To achieve the Cosine PPP targets in particular for the high health needs group/
In the delivery of health campaigns we will contact each patient in the high health needs group by phone or text and offer appointments at convenient times e.g. after hours.	To remove barriers to access in order to provide care to all patients.
Continue to develop programmes tailored to this group	To increase the utilisation rates in the high needs group to address health disparities.
Prioritise Long Term Conditions. We now have a nurse clinic 1.5 days per week that is dedicated to the management of LTC.	Increase screening rates and improve outcomes for those with long term conditions.
KMC recognises the need to support on-going professional development to support the work around delivery of services to the High Health needs group and those working to improve outcomes for patients with long term conditions.	Identify professional development pathways. Subsidise training relevant to the identified health needs of the local population.

KMC - Services to Improve Access

BACKGROUND			BUDGET INFORMATION			
Initiative	Provider of Service - eg. practice, PHO and details of type of staff eg. GP, nurse etc	New Initiative Y/N	1 July 2015 to 30 June 2016 Budget allocation	Underspend from 2014/2015 and previous yrs (do not fill in if this is a new initiative)	Will this underspend be applied to initiative in 2015/2016? If not, where will underspend be applied?	Total Budget in 2015/2016 for this initiative (Underspend + 2015/2016 budget)
Healthy Families	Practice: GP/Nurse/Reception	N	$15,115	$3,384		$18,499
Hospital Discharge	Practice: GP/Nurse/Reception	N	$15,331	$4,106	$15,000	$34,437
Emergency Department Attendances	Practice: GP/Nurse/Reception	N	$0	$0		$0
Interpreting Services	PHO (through Wellington Interpreting Services)	N	$648	$959		$1,607
Low Cost Prescriptions	Practice: GP/Nurse/Reception	N	$3,714	$961		$4,674
Transport Initiative	PHO: Admin	N	$1,900	$972		$2,872
Immunisation Services & Outreach	PHO & KMC-GPs & Nurses	N	$0	$711		$711
Administration		N	$6,478	$498		$6,976
Total			**$43,185**	**$11,590**	**$15,000**	**$69,775**

Transfer from HP

KMC - Health Promotion

BACKGROUND			BUDGET INFORMATION			
Initiative	Provider of Service - eg. practice, PHO and details of type of staff eg. GP, nurse etc	New Initiative Y/N	1 July 2015 to 30 June 2016 Budget allocation	Underspend from 2014/2015 and previous yrs (do not fill in if this is a new initiative)	Will this underspend be applied to initiative in 2015/2016? If not, where will underspend be applied?	Total Budget in 2015/2016 for this initiative (Underspend + 2014/2015 budget)
Best Practice Services	KMC-GPs and Nurses	N	$8,429	$623		$9,052
Diabetes Group Education Sessions	PHO-contracted provider	N		$0	$4,000	$4,000
Health Campaigns	KMC-GPs and Nurses	N	$19,127	$6,107	-$16,000	$9,234
Increasing Activity	PHO	N		$1,000		$1,000
Maori Health	PHO	N		$3,000	-$1,000	$2,000
Training & Education		N		$2,000	-$1,000	$1,000
Youth Health	PHO & KMC-GPs & Nurses	N		$3,000	-$1,000	$2,000
Administration		N	$4,863	$3		$4,866
Total			**$32,418**	**$15,733**	**-$15,000**	**$33,151**

Transferred to SIA

Ropata Medical Centre

SIA and HP Plan

2015-16

Introduction

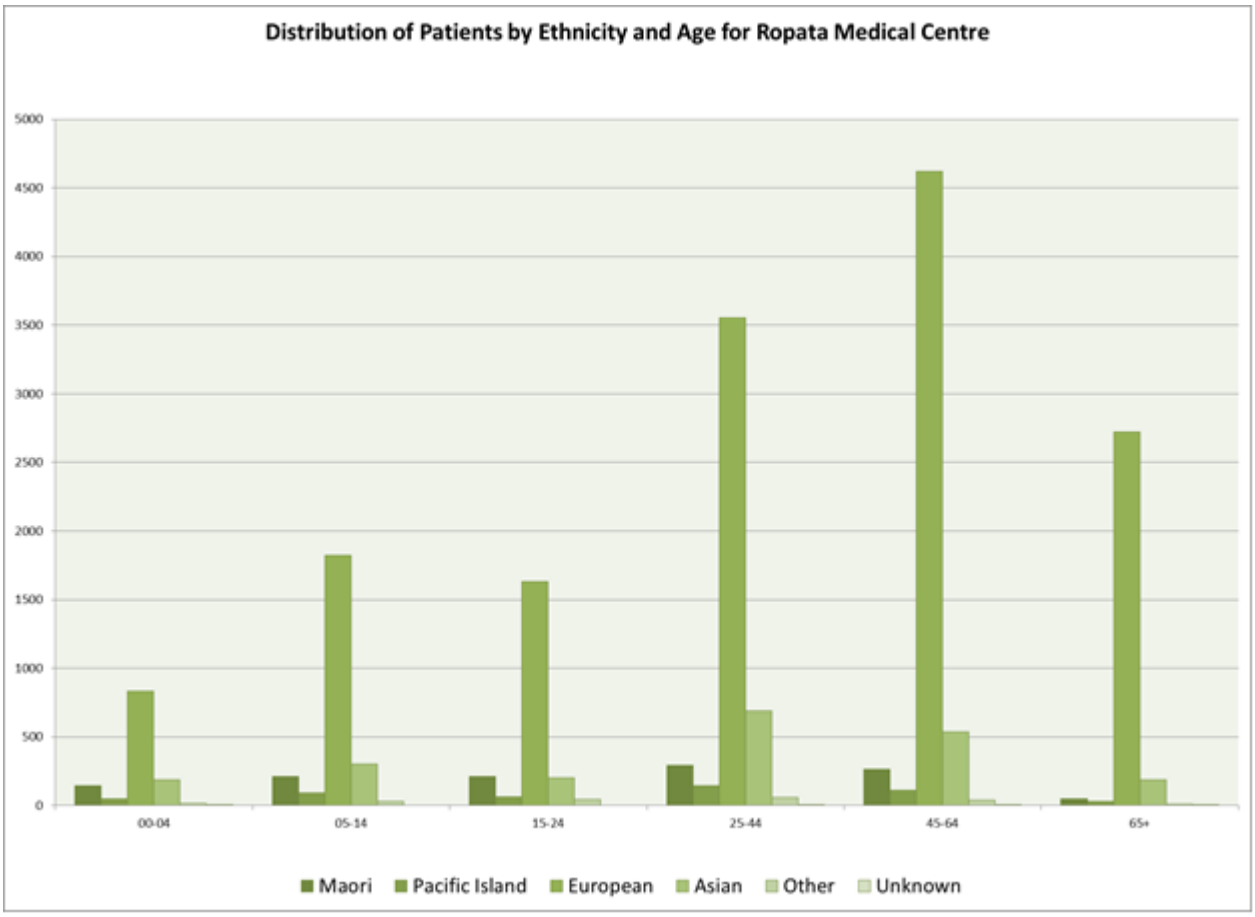
Ropata Medical Centre has a current enrolled patient population of 19, 312 with patient numbers increasing steadily year on year.

RMC's patient population consists of:

- 6% Maori
- 3% Pacific
- 10% Quintile 5 Non Maori or Pacific
- 10% Asian

Proportion for Maori and Pacific peoples have remained stable for a number of years, irrespective of register growth. However, we have seen a steady increase in our Asian population and this may be due patient requiring access to one of our associates who speaks Mandarin and Chinese.

RMC's distribution by age and ethnicity is shown in the graph below.



Summary

This Services to Improve Access and Health Promotion Business Plan covers the period from 1 July 2015 to 30th June 2016.

Ropata Medical Centre's vision statement is to **"Provide high quality primary care services, recognising the need for integration, resulting in a practice which staff want to work at, patients want to join, and as a result continue to be a leader in General Practice".**

Focus for 2015-16

1. To prioritise services to those patient groups most in need
2. To provide high quality services within the PHO funding provided
3. To maximise use of health promotion funding to reduce future long term health conditions of RMC's patients.
4. To ensure we improve or continue to meet the Ministry of Health targets relating to Primary Care.
5. To improve on better utilising SIA funding for those patients most in need.

Priorities for 2015/16

1. To work in alliance with the DHB and other local health providers to identify and target those patient most in need through best utilisation of PHO funds
2. Strive for quality services which are sooner and closer to home.
3. To collaborate and contribute to the local long term conditions plan

Services to Improve Access

SIA Initiatives	Service Delivery
Outreach Nurse	1 FTE senior nurse to focus on improving access for high needs patients in the delivery of clinic appointments and outreach visits.
Admin support	Part funding for admin support to focus on recalling high needs patients for participation in key screening activities and health targets.
Easier Access for staff for utilising SIA funding	An SIA account holder account set up in MEDTECH to allow staff easier access to be able to invoice services if staff feels these are appropriate. Services offered are: • GP appointments • Nurse appointments • Tests such as ECGs, spirometry, etc. • Transport paid to appointments to RMC or hospital • Prescriptions
Outreach vehicle	Use of SIA funds to cover maintenance and fuel costs of vehicle to use in outreach visits

Health Promotion Initiatives

Health Promotion Initiatives	Service Delivery
Smoking Cessation Advisor	RMC's Healthcare Assistant dedicates 5 hours per week targeting current smokers for smoking cessation advice by text messaging, telephone and face to face contact. This is to support achieving our IPIF target.
Pre-Diabetes Screening	Utilise Health promotion funding to target pre-diabetic patients. Patients will be identified through virtual screening of

	HBA1C results, sent a letter and resource pack and offered a free pre-diabetic Nurse appointment.
Health campaigns	RMC participate in various national health promotion campaigns such as Stoptober and National Cancer week.
More heart and diabetic checks	The use of the predict tool is used for the delivery of more heart and diabetic checks to standardise reporting.

Services to Improve Access Funding 2015/16

INCOME	Revenue in advance	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Projected
Services to Improve Access		9267	9267	9267	9267	9267	9267	9267	9267	9267	9267	9267	9267	111,207
Other income (imms)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Promotion	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Income	**0**	9,267	9,267	9,267	9,267	9,267	9,267	9,267	9,267	9,267	9,267	9,267	9,267	111,207
EXPENDITURE														
Wages (Nurse)		8,725	8,725	8,725	8,725	8,725	8,725	8,725	8,725	8,725	8,725	8,725	8,725	104,699
Wages (Admin)		1,154	1,154	1,154	1,154	1,154	1,154	1,154	1,154	1,154	1,154	1,154	1,154	13,848
Motor vehicle		0	0	0	468	0	0	0	563	0	0	0	248	0
Other costs		0	0	0	0	0	0	0	0	0	0	0	0	0
Total Expenditure		9,879	9,879	9,879	10,347	9,879	9,879	9,879	10,442	9,879	9,879	9,879	10,127	118,547
Monthly Profit/Loss		-612	-612	-612	-1,080	-612	-612	-612	-1,175	-612	-612	-612	-860	
Year to Date Profit/Loss		-612	-1,223	-1,835	-2,914	-3,526	-4,138	-4,750	-5,924	-6,536	-7,148	-7,760	-8,619	-7,340

Health Promotion Funding

INCOME	Revenue in advance	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Projected
Health Promotion		3665	3665	3665	3665	3665	3665	3665	3665	3665	3665	3665	3665	43,980
Other income	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Income	0	3,665	3,665	3,665	3,665	3,665	3,665	3,665	3,665	3,665	3,665	3,665	3,665	43,980
EXPENDITURE														
Wages (Nurse)														0
Wages (Admin)		728	728	728	728	728	728	728	728	728	728	728	728	8,736
Other costs		633	633	633	633	633	633	633	633	633	633	633	633	7,596
Total Expenditure		1,361	1,361	1,361	1,361	1,361	1,361	1,361	1,361	1,361	1,361	1,361	1,361	16,332
Monthly Profit/Loss		2,304	2,304	2,304	2,304	2,304	2,304	2,304	2,304	2,304	2,304	2,304	2,304	
Year to Date Profit/Loss		2,304	4,608	6,912	9,216	11,520	13,824	16,128	18,432	20,736	23,040	25,344	27,648	27,648

*Other costs predict licence $633 per month

Under Spend 2015/16

RMC have recently began its pre-diabetes project, utilising the under spend in Health Promotion funding to identify and target pre-diabetic patients to improve the long term health outcomes of this group of patients.

Patients will be identified through virtual screening of their HBA1C, and then contacted via an information letter and resource pack. The letter will offer the patient a free pre-diabetic Nurse appointment.

Leadership

Ropata Medical Centre

Dr Chris Masters

- Member of Hutt INC, Alliance Leadership Team
- Clinical Lead for Hutt INC "Enablers" work stream
- Clinical Lead Health Pathways, 3DHB
- Member of HV Community Radiology Advisory Group
- Board Member of Patients First Ltd

Dr Paul Rowan

- Member of Hutt INC, Long Term Conditions Clinical Network

Dr Sarah Painter

- Member of Hutt INC, Acute Care Clinical Network

Dr Gillian Yardley

- Member of Hutt INC, Child Health Clinical Network

Dr Stewart Reid

- Chair of National Immunisation Technical Forum 1980-2011
- Member of HVDHB CPHAC 2008-11

Karori Medical Centre

Dr Jeff Lowe

- Clinical Champion for the CCDHB ICC Long Term Conditions Group
- Member of the DHBs Leaders Group
- Member of the Patients First steering group
- Deputy chair of GPNZ
- Member of the ICC Alliance Leadership Team

Dr Peter Moodie

- Chair of the Primary Care Working Group providing advice to the Minister of Health
- Chair of the ICC Medicines Management Group

Dr Ros Wall

- Member of the Diabetes Clinical Network

Dr Myrto Kenny

- Community Radiology Advisory Group

Lyn Allen

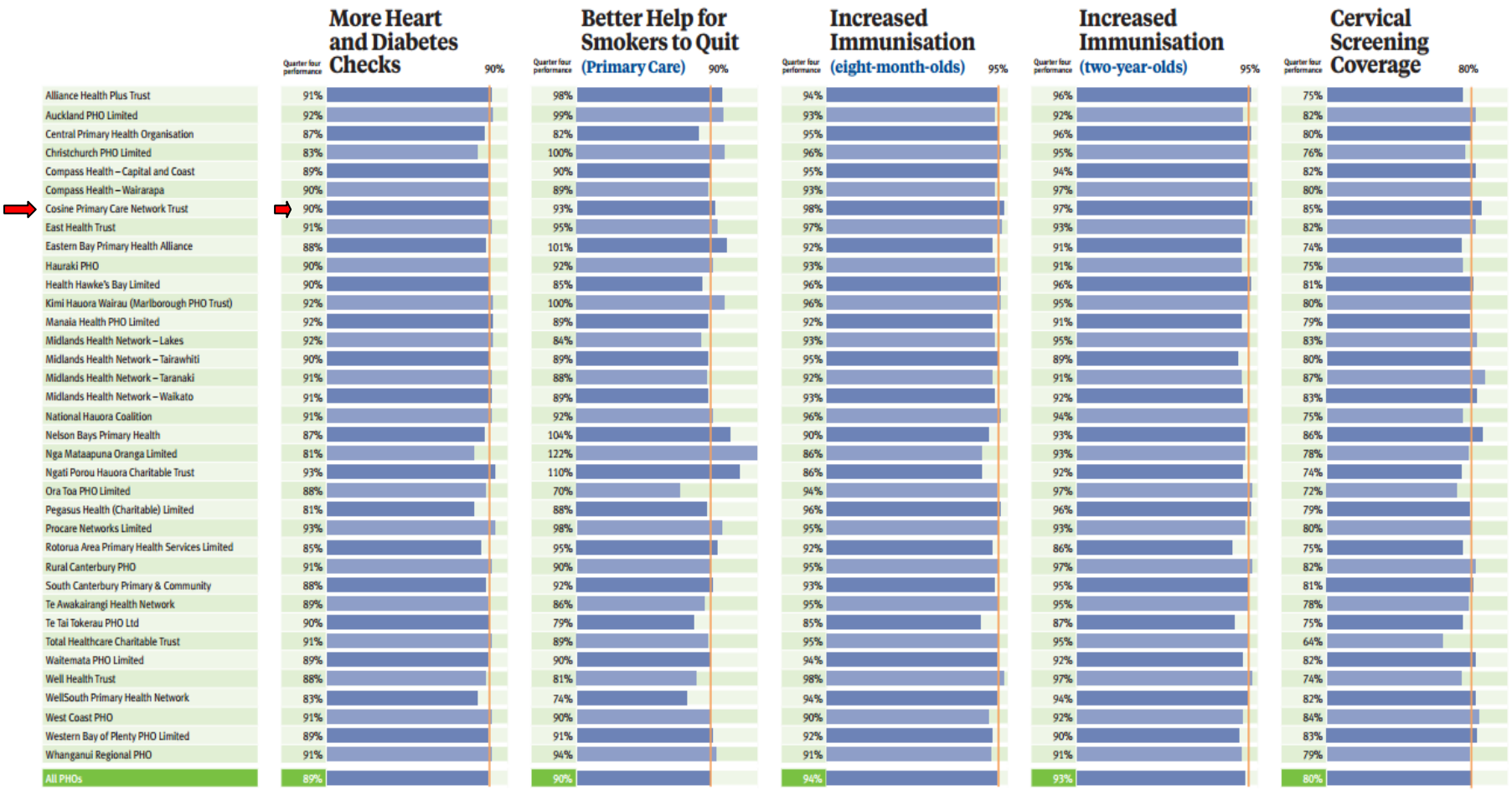
- Member of the 3DHB Integrated Laboratory Clinical Reference Group (CRG)

How is My PHO performing?

for the 5 transitional IPIF measures

MINISTRY OF HEALTH
MANATŪ HAUORA

2014/15 QUARTER FOUR (APRIL TO JUNE) RESULTS



More information on the Integrated Performance and Incentive Programme can be found on www.health.govt.nz/IPIF

National Ranking by Performance

1	Ngati Porou Hauora Charitable Trust	93%
2	Procare Networks Limited	93%
3	Auckland PHO Limited	92%
4	Manaia Health PHO Limited	92%
5	Kimi Hauora Wairau (Marlborough PHO Trust)	92%
6	Midlands Health Network – Lakes	92%
7	East Health Trust	91%
8	Midlands Health Network – Taranaki	91%
9	Alliance Health Plus Trust	91%
10	Rural Canterbury PHO	91%
11	West Coast PHO	91%
12	Total Healthcare Charitable Trust	91%
13	Midlands Health Network – Waikato	91%
14	National Hauora Coalition	91%
15	Whanganui Regional PHO	91%
16	Health Hawke's Bay Limited	90%
17	Te Tai Tokerau PHO Ltd	90%
18	Cosine Primary Care Network Trust	90%
19	Compass Health – Wairarapa	90%
20	Hauraki PHO	90%
21	Midlands Health Network – Tairawhiti	90%
22	Waitemata PHO Limited	89%
23	Western Bay of Plenty PHO Limited	89%
24	Compass Health – Capital and Coast	89%
25	Te Awakairangi Health Network	89%
26	Eastern Bay Primary Health Alliance	88%
27	Well Health Trust	88%
28	Ora Toa PHO Limited	88%
29	South Canterbury Primary & Community	88%
30	Nelson Bays Primary Health	87%
31	Central Primary Health Organisation	87%
32	Rotorua Area Primary Health Services Limited	85%
33	WellSouth Primary Health Network	83%
34	Christchurch PHO Limited	83%
35	Nga Mataapuna Oranga Limited	81%
36	Pegasus Health (Charitable) Limited	81%
	All PHOs	89%

More Heart & Diabetes Checks

1	Nga Mataapuna Oranga Limited	122%
2	Ngati Porou Hauora Charitable Trust	110%
3	Nelson Bays Primary Health	104%
4	Eastern Bay Primary Health Alliance	101%
5	Kimi Hauora Wairau (Marlborough PHO Trust)	100%
6	Christchurch PHO Limited	100%
7	Auckland PHO Limited	99%
8	Procare Networks Limited	98%
9	Alliance Health Plus Trust	98%
10	East Health Trust	95%
11	Rotorua Area Primary Health Services Limited	95%
12	Whanganui Regional PHO	94%
13	Cosine Primary Care Network Trust	93%
14	Hauraki PHO	92%
15	National Hauora Coalition	92%
16	South Canterbury Primary & Community	92%
17	Western Bay of Plenty PHO Limited	91%
18	Rural Canterbury PHO	90%
19	Compass Health – Capital and Coast	90%
20	West Coast PHO	90%
21	Waitemata PHO Limited	90%
22	Midlands Health Network – Tairawhiti	89%
23	Manaia Health PHO Limited	89%
24	Compass Health – Wairarapa	89%
25	Total Healthcare Charitable Trust	89%
26	Midlands Health Network – Waikato	89%
27	Midlands Health Network – Taranaki	88%
28	Pegasus Health (Charitable) Limited	88%
29	Te Awakairangi Health Network	86%
30	Health Hawke's Bay Limited	85%
31	Midlands Health Network – Lakes	84%
32	Central Primary Health Organisation	82%
33	Well Health Trust	81%
34	Te Tai Tokerau PHO Ltd	79%
35	WellSouth Primary Health Network	74%
36	Ora Toa PHO Limited	70%
	All PHOs	90%

Better Help for Smokers to quit

1	Cosine Primary Care Network Trust	98%
2	Well Health Trust	98%
3	East Health Trust	97%
4	Health Hawke's Bay Limited	96%
5	Kimi Hauora Wairau (Marlborough PHO Trust)	96%
6	Pegasus Health (Charitable) Limited	96%
7	Christchurch PHO Limited	96%
8	National Hauora Coalition	96%
9	Central Primary Health Organisation	95%
10	Compass Health – Capital and Coast	95%
11	Te Awakairangi Health Network	95%
12	Procare Networks Limited	95%
13	Rural Canterbury PHO	95%
14	Midlands Health Network – Tairawhiti	95%
15	Total Healthcare Charitable Trust	95%
16	WellSouth Primary Health Network	94%
17	Ora Toa PHO Limited	94%
18	Alliance Health Plus Trust	94%
19	Waitemata PHO Limited	94%
20	Midlands Health Network – Waikato	93%
21	Midlands Health Network – Lakes	93%
22	South Canterbury Primary & Community	93%
23	Auckland PHO Limited	93%
24	Hauraki PHO	93%
25	Compass Health – Wairarapa	93%
26	Eastern Bay Primary Health Alliance	92%
27	Western Bay of Plenty PHO Limited	92%
28	Rotorua Area Primary Health Services Limited	92%
29	Manaia Health PHO Limited	92%
30	Midlands Health Network – Taranaki	92%
31	Whanganui Regional PHO	91%
32	Nelson Bays Primary Health	90%
33	West Coast PHO	90%
34	Ngati Porou Hauora Charitable Trust	86%
35	Nga Mataapuna Oranga Limited	86%
36	Te Tai Tokerau PHO Ltd	85%
	All PHOs	94%

8 month Immunisations