Annual Report 2016

Cosine
Primary Care Network

Report for the period 1 July 2015– 30 June 2016

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 33,780 patients. Of these 6% are Maori, 3% are Pacific and 13% Asian.

13% 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 2015-16 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.

Two national reviews undertaken in this reporting period will impact on Primary Health care.

In August 2015 the Minister of Health established a sector-based Primary Care Working Group to provide him with advice on:

- ensuring affordable, equitable access to sustainable general practice
- general practice workforce sustainability
- shifting services closer to home

The General Practice Sustainability report produced by the group was released in February 2016. This report was informed by direct contact with over 600 people involved in general practice services through 11 consultation forums conducted between Whangarei and Dunedin in September 2015, as well as an online survey.

The report recommended that the current VLCA funding be reallocated to an enrolled patient level, rather than being allocated at a practice level. The Primary Care Working Group found the lack of targeted support for people with high health needs and low incomes in the existing funding formula is a major problem for both patients and general practices.[2]

The review of the New Zealand Health Strategy, Future Direction[3], was released in April 2016. There are five strategic themes for change articulated in the report.

1. People powered
    - making New Zealanders 'health smart'; that is, they can get and understand the information they need to manage their care
    - enabling individuals to make choices about the care or support they receive
    - understanding people's needs and preferences and partnering with them to design services to meet these
    - communicating well and supporting people's navigation of the system, including through the use of accessible technology such as mobile phones and the internet.
2. Closer to home
    - providing care closer to where people live, learn, work and play, especially for managing long-term conditions

[2] http://gpnz.org.nz/wp-content/uploads/PCWG-General-Practice-Sustainability-Public-Report.pdf

[3] http://www.health.govt.nz/publication/new-zealand-health-strategy-2016

- integrating health services and making better connections with wider public services
- promoting wellness and preventing long-term conditions through both population-based and targeted initiatives
- investing in health and wellbeing early in life and focusing on children, young people, families and whānau

3. Value and high performance
    - delivering better outcomes relating to people's experience of care, health status and best-value use of resources
    - striving for equitable health outcomes for all New Zealand population groups
    - measuring performance well and using information openly to drive learning and decision-making that will lead to better performance
    - building a culture of performance and quality improvement that values the different contributions the public and health workforce can make to improving services and systems
    - having an integrated operating model that makes responsibilities clear across the system
    - using investment approaches to address complex health and social issues
4. One team
    - operating as a team in a high-trust system that works together with the person and their family and whānau at the centre of care
    - using our health and disability workforce in the most effective and most flexible way
    - developing leadership, talent and workforce skills throughout the system
    - strengthening the roles of people, families, whānau and communities as carers
    - the Ministry of Health leading the system effectively
    - collaborating with researchers.
5. Smart system
    - discovering, developing and sharing effective innovations across the system
    - taking advantage of opportunities offered by new and emerging technologies
    - having data and smart information systems that improve evidence-based decisions, management reporting and clinical audit
    - having reliable, accurate information that is available at the point of care
    - providing individual online health records that people are able to access and contribute to
    - using standardised technology that allows us to make changes easily and efficiently.

Cosine is actively implementing services, and using systems and processes, which support the actions arising from the 2016 Health Strategy.

For example, under the themes 'Closer to home' and 'Value and Performance' the imperative from CCDHB to reduce ambulatory sensitive hospital admission (ASH) rates is being addressed through the provision of primary options for acute care (POAC). Launched in 2014, POAC provides patients with alternative treatment options to the Emergency Department. POAC is a service which enables primary care providers to maximise the management of their acute patients in the community[4]. Patients can now have an intravenous infusion of antibiotics to treat cellulitis or an anticoagulant to treat a deep vein thrombosis administered at the practice.

Under the theme Value and High Performance, Cosine continues to achieve at a high level across the MOH targets. Cosine participated in the discussions to inform CCDHB's System Level Measures Plan and in the selection of the contributory measures. Contributory measures have a quality improvement focus and are front line service level measurements that show a tangible and meaningful result of the interaction between clinicians and patients.[5] Examples are risk stratification of those at high risk of admission, increasing the rates of flu vaccination and increasing enrolment of children in the dental service, Bee Healthy.

'Smart systems' have been implemented through use of the patient portal and Health Pathways. Both practices have championed the use of patient portals, enabling better access for patients to health information and services. Health Pathways have been set up as a resource for general practitioners, easily accessed through an icon on the desktop.The online resource is designed for primary health care practitioners to use during consultation, helping them manage and refer their patients to the most appropriate specialist, hospital or community-based services. This not only helps patients get the right care, but greatly improves relationships between the people involved[6].

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

The financial impact on the primary care sector through a reduction in funding for contracted services continues. Funding for Mental Health services in primary care was reduced across all the PHO's in 2016. Sexual Health services funding was reduced again and will cease in 2017. The funding for cardiovascular risk assessments was reduced significantly and ceased at the end of 2016. Diabetes and Pharmacy Facilitation have remained the same.

[4] POAC final media release DVT 1122016

[5] http://www.health.govt.nz/new-zealand-health-system/system-level-measures-framework/system-level-measures-framework-questions-and-answers#2

[6] http://www.huttvalleydhb.org.nz/health-professionals/healthpathways/

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 2016

The following seven objectives were the focus for the Business Plan 2015-16

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 maintained the high performance of previous years. A letter from Jonathan Coleman to Virginia Hope, Chairman of CCDHB and Hutt Valley DHBs, commented on Cosine's achievements for Q4, 2016. Comments from the target champions are copied below.

John McMenamin, Co-Target Champion, *better help for smokers to quit*
The national result for the quarter three primary care target is 86 percent, an increase of 1 percent. Capital & Coast DHB did not achieve the target this quarter but well done on increasing your result, keep this up and strive for an achieved result.

Cosine Primary Care Network (Capital & Coast) achieved the target this quarter. However, Compass Health, Well Health Trust and Ora Toa PHOs did not achieve the target.

Pat Tuohy, Target Champion, *increased immunisation*

The performance for infant immunisation across the PHOs in the region was variable, with outstanding results from Cosine Primary Care Network (100 percent coverage among practices in the Capital & Coast DHB area) and good results from Compass Health (94.7 percent). However, Well Health Trust and Ora Toa PHOs did not meet target.

Pat Tuohy, Target Champion, *increased immunisation*
It is pleasing to see that performance for Hutt Valley DHB against the infant immunisation health target is returning towards the good levels that the DHB previously achieved. Coverage in this quarter was 94.3 percent. Please pass on our thanks to all your team.

Coverage for Te Awakairangi Health Network increased slightly to 94.1 percent, while coverage was 98.5 percent among the Cosine practices in the Hutt Valley area.

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. An example is the provision of a range of POAC services.

3. Sharing of Innovative ideas

At a local level the practices openly share systems and process that aid workflow. Examples are the self-check in kiosk at Ropata Medial Centre, which frees up reception staff, and the archived file system at Karori Medical Centre which has been adopted by a number of practices in the region. Leaders from both practices are involved in discussions with the wider health network which generate and share ideas for improvement.

4. Engaging with DHBs in the delivery of new programmes

The clinical leads continue in their established roles within Hutt INC and the ICC and there is increasing participation from other representatives from both practices.

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. The recommendations from the General Practice sustainability report will be of interest to all those working in primary care. Contract funding has been further reduced in this reporting period. Both practices meet the short fall for from practice funds to ensure that service delivery continues

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

Payments were at 100% with the exception of Better Help for Smokers to Quit which was 84%. However a grand parented performance payment component was applied which ensured that there was no shortfall.

7. To attract funding for innovative pilot projects

The Health care Home model of care is being piloted in the CCDHB region. Karori Medical Centre has been selected as a tranche 1 practice. The practice will receive $14 per enrolled patient when all the initial criteria are met and the contract signed off. Hutt Valley DHB is expected to consider funding the HCH model in 2017 and at that stage Ropata Medical Centre may consider adopting the model of care.

System Level Measures and Health Targets

No new measures were added to the IPIF programme for 2015-16. From July 2016 the more heart and diabetes checks results will no longer be reported as a health target.

COSINE PERFORMANCE ACROSS THE THREE MOH HEALTH TARGETS					
	1 Apr – 30 Jun 16	1 Jan – 31 Mar 16	1 Oct- 31 Dec 15	1 Jul - 30 Sep 15	1 Apr - 30 Jun 15
Health Target	**Q4**	**Q3**	**Q2**	**Q1**	**Q4**
Increased Immunisation (95%)	**3** 99%	**1** 99%	**5** 97%	**3** 98%	**1=** 98%
Better help for Smokers to Quit (90%)	**27** 84%	**16** 87%	**26** 81%	**13** 87%	**13** 93%
More Heart and Diabetes Checks (90%)	**27** 90%	**25** 90%	**23** 90%	**23** 90%	**18** 90%

Over the 36 PHOs rates of

- immunisation ranged from 82% to 100% with an average of 94%
- help for smokers rates ranged from 78% - 93% with an average of 88%
- more heart and diabetes checks rates ranged from 85% - 94% with an average of 91%

From 1 July 2016 the following system level measures will be implemented

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates under 75 years.

ACHIEVEMENTS IN 2015-16

Karori Medical Centre

1. **EOI to join tranche 1 of the Health Care Home model of care approved.**
2. **Enrolments in Manage My Health- the patient portal.**

Enrolment levels in the patient portal are amongst the best nationally. As at 1 July 2016 69% (7692) of the eligible population were registered to the portal.

3. **Continued High Performance in 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. **National Enrolment Service**

Karori Medical centre joined tranche 1 in the implementation of the NES. NES is a system that integrates directly with the practice management system via a secure web link in to the MOH national identity and payment system. The practice liaised with Medtech and MOH personnel to identify glitches in the system.

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 83 (39 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. **Partnership with Kokiri Marae to run smoking cessation clinics**

2. **Planning towards an Outreach service in partnership with Kokiri Marae**

Discussions are underway with Kokiri Marae to explore utilising their mobile clinics to carry out outreach work for cervical smears and immunisations.

3. **Cervical Smear campaign for the high health needs group**

The aim of the campaign is to improve access to screening services for those who are currently disengaged from the healthcare. There was a 35% success rate in this campaign and a second will be run later in the year.

4. **Primary Options for Acute Care (POAC)**

The practice has expanded services from the treatment of cellulitis to include severe respiratory illness and bowel obstructions. Other services will be offered as the Health Pathways and POAC services are developed.

5. **Workplace Immunisations for staff at two schools.**

6. **Extended Nurse support**

The practice will improve support for patients and GPs by extending nursing hours up until 10.00pm on weekdays and all day both Saturday and Sunday.

7. **Manage my Health**

RMC have significantly increased enrolments in the patient portal.

LOOKING FORWARD

Karori Medical Centre
SIA & HP Plan
2016-17

Karori Medical Centre has 14,418 enrolled patients (1st January 2016). Of these 11% are identified as High Needs.[7]Patients are residents of Karori, Wellington and its environs.

KMC's patient population consists of:

- 5.0 % Maori
- 3.0 % Pacific
- 1.0 % Dep 5
- 15.0 % Asian

The percentage of the population who identify as Asian has continued to increase while the number of high health needs patient has reduced slightly from the previous year.

The graph below shows the distribution of the enrolled population by age and ethnicity.

Summary

This Services to Improve Access and Health Promotion plan covers the period from 1 July 2016 to 30 June 2017.

Karori Medical Centre is committed to providing quality patient care that is culturally sensitive for all its patients. KMC strives to review and improve its services and the access for all patients to appropriate medical services which meet their needs. We aim co-ordinate the needs of those with chronic disease so that the services patients receive are timely and integrated.

The team are forward facing and take pride in being able to respond quickly to new initiatives and directions in health care.

The services provided are well embedded and are part of business as usual.

The Cosine Board have asked the practices to consider how they will respond to the Childhood Obesity Strategy and there was been discussions on beginning by recording the weight and height of children in a systematic way.

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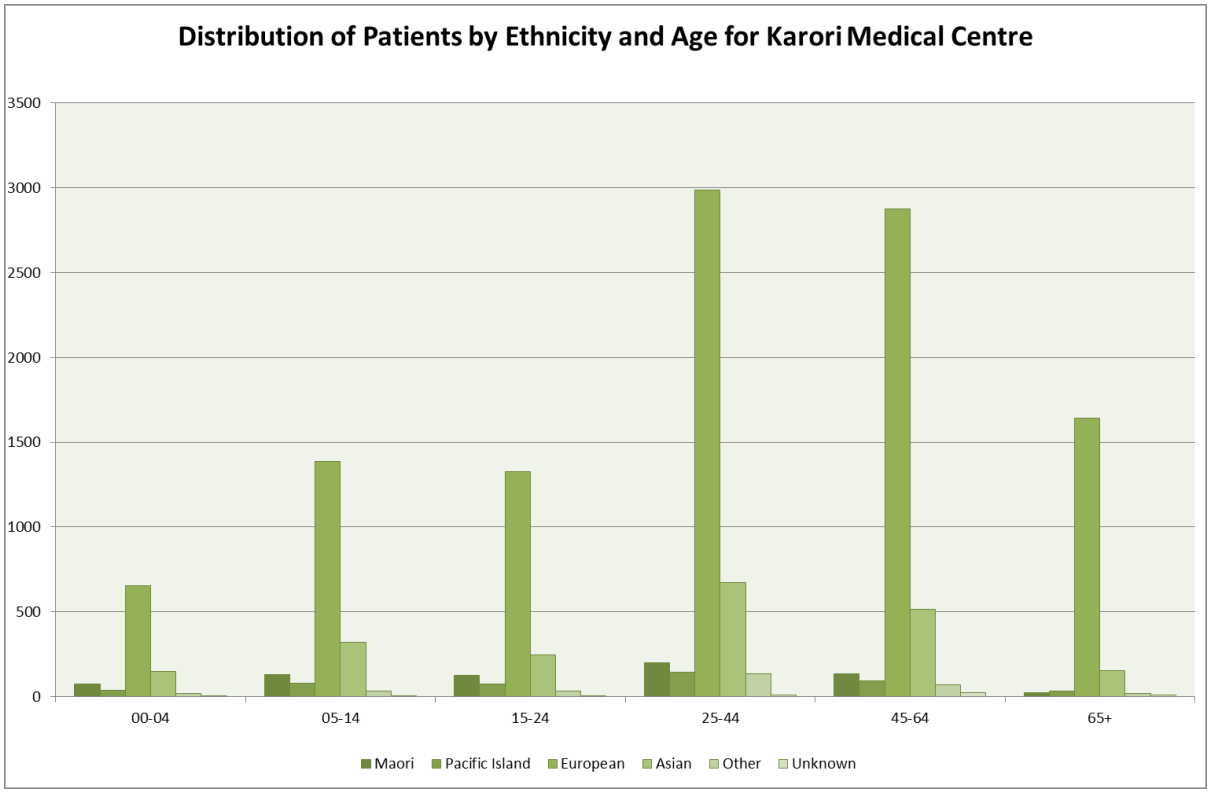
[7] High Need Groups are defined as groups of persons who are Maori, Pacific and/or person residing in New Zealand Deprivation Index deciles 9 &10 areas. *Capital & Coast DHB/ KPHO Contract Version 18.0*



Key Achievements 2015-16

1. Health Care Home (HCH). KMC was accepted to be one of the nine practices moving to the HCH model of care.

2. Successful TAS audit.

3. Continued support of families and whanau through initiatives such as Healthy Families, Low Cost Prescriptions and the Transport Initiative.

4. Increased access to services for patients through the patient portal, Manage My Health. With 4,846 active users we are able to measure the reduction in the number of phone calls in to the practice.

Priorities for 2016-17

- Full implementation of the Health Care Home model of care.
- Increase enrolment in MMH to over 85%
- Increase the number of POAC services
- Improve access through extending the hours of the nurse clinics and the Saturday service (currently morning only)

The services funded through SIA will continue to be provided in 2016-2017

SERVICES TO IMPROVE ACCESS INITIATIVES

Initiative	Service Delivery	Actions	Targets
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.	Monthly review to ensure that patients in need are on the programme. We have robust financial reporting	To work within budget. Currently there are 90 individuals from 32 families supported by the programme. Average consults are 30 a month.
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.	Daily review of the discharge list. Patients are contacted and offered a free appointment with their GP. To link to the predictive risk modelling that is underway. The risk modelling is part of the year of care planning for the HCH and will give us better understanding of the reasons for readmission. The second part of the discharge initiative is reviewing emergency department attendances with the aim of treating patient with chronic conditions in a planned way, reducing visits to ED.	Reduction in the re-admission rates. Average consults are 55 a month.
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.	Proactively offer the service.	Increase the use of Language Line.
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.		Maintain current volumes within budget; on average 10 a month.
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.		Maintain current volumes within budget.

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 2016 to 30 June 2017 Budget allocation	Underspend from 2015/2016 and previous yrs (do not fill in if this is a new initiative)	Will this underspend be applied to initiative in 2016/2017? If not, where will underspend be applied?	Total Budget in 2016/2017 for this initiative (Underspend + 2016/2017 budget)
Healthy Families	Practice: GP/Nurse/Reception	N	$13,920	$2,475	$5,711	$22,106
Hospital Discharge	Practice: GP/Nurse/Reception	N	$12,354	$5,585	$10,000	$27,939
Interpreting Services	PHO (through Wellington Interpreting Services)	N	$348	$1,223		$1,571
Low Cost Prescriptions	Practice: GP/Nurse/Reception	N	$2,436	$1,739		$4,175
Transport Initiative	PHO: Admin	N	$522	$1,508		$2,030
Immunisation Services & Outreach	PHO & KMC-GPs & Nurses	N	$0	$711	-$711	$0
Administration		N	$5,220	$497		$5,717
Total			**$34,800**	**$13,738**	**$15,000**	**$63,538**
					Transfer from HP	

Note:

1	Underspend as at 30 June 2016 - estimate	$13,738
	budget income	$34,800
	budget to transfer $15,000 from HP to SIA in April 2016	$15,000
	Total fund available for SIA for period July 2016 to June 2017	$63,538

HEALTH PROMOTION INITIATIVES

Initiative	Service Delivery	Actions	Targets
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.	Continue to develop programmes tailored to this group. To increase the utilisation rates in the high needs group to address health disparities.	To remove barriers to access in order to provide care to all patients. Increase screening rates and improve outcomes for those with long term conditions.
Increasing Activity	Subsidised visits to the local recreation centre and pool.	People with a leisure card receive up to a 50% discount. KMC will pay the remaining 50% for patients who want to increase their activity levels. Beginning with those diabetics under active management, we will monitor the activity for effectiveness and then roll it out to patients with other long term conditions.	30 patients supported.
Liaison	Supporting collaboration and	Initiate discussions on	Begin by recording the

	networking with other CCDHB PHOs	childhood obesity and family violence with the CCDHB PHOs.	weight/height of children at their immunisation visits. Complete motivational interviewing training in regard to family violence.
Maori Health	Collaborate with the Maori health Directorate at CCDHB in their planning	The Cosine Board has considered the annual Maori Health and asked the practices to make dental health of children, diabetes and cardiovascular risk assessments a priority.	
Training & Education	To support those delivering the contractual requirements of Cosine PHO (Karori) to undertake appropriate training. E.g. e learning for diabetes management	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.	
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.	Reconnect with the local groups to ensure that they are aware of this initiative.	Provide 30 free consultations for this age group.

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 2016 to 30 June 2017 Budget allocation	Underspend from 2015/2016 and previous yrs (do not fill in if this is a new initiative)	Will this underspend be applied to initiative in 2016/2017? If not, where will underspend be applied?	Total Budget in 2016/2017 for this initiative (Underspend + 2015/2016 budget)
Best Practice Services	KMC-GPs and Nurses	N	$11,306	$986	-$3,000	$9,292
Diabetes Group Education Sessions	PHO-contracted provider	N		$4,000	-$4,000	$0
Health Campaigns	KMC-GPs and Nurses	N	$16,152	$535	-$8,000	$8,687
Increasing Activity	PHO	N		$1,000		$1,000
Maori Health	PHO	N		$2,000		$2,000
Training & Education		N		$1,000		$1,000
Youth Health	PHO & KMC-GPs & Nurses	N		$2,000		$2,000
Administration		N	$4,846	$4		$4,850
Total			**$32,304**	**$11,525**	**-$15,000**	**$28,829**

Transferred to SIA

Note:

1 Underspend as at 30 June 2016 - estimate $11,525
Budget Transfer to SIA initiative in April 2016 -$15,000
Budget income $32,304
Total fund available for HP for period July 2016 to June 2017 $28,829

Ropata Medical Centre
SIA & HP Plan
2016-17

Introduction

Ropata Medical Centre has a current enrolled patient population of 19, 259 with patient numbers increasing steadily year on year.

RMC's patient population consists of:

- 6.1% Maori
- 2.5% Pacific
- 9.7% Quintile 5 Non Maori or Pacific
- 11.6% Asian

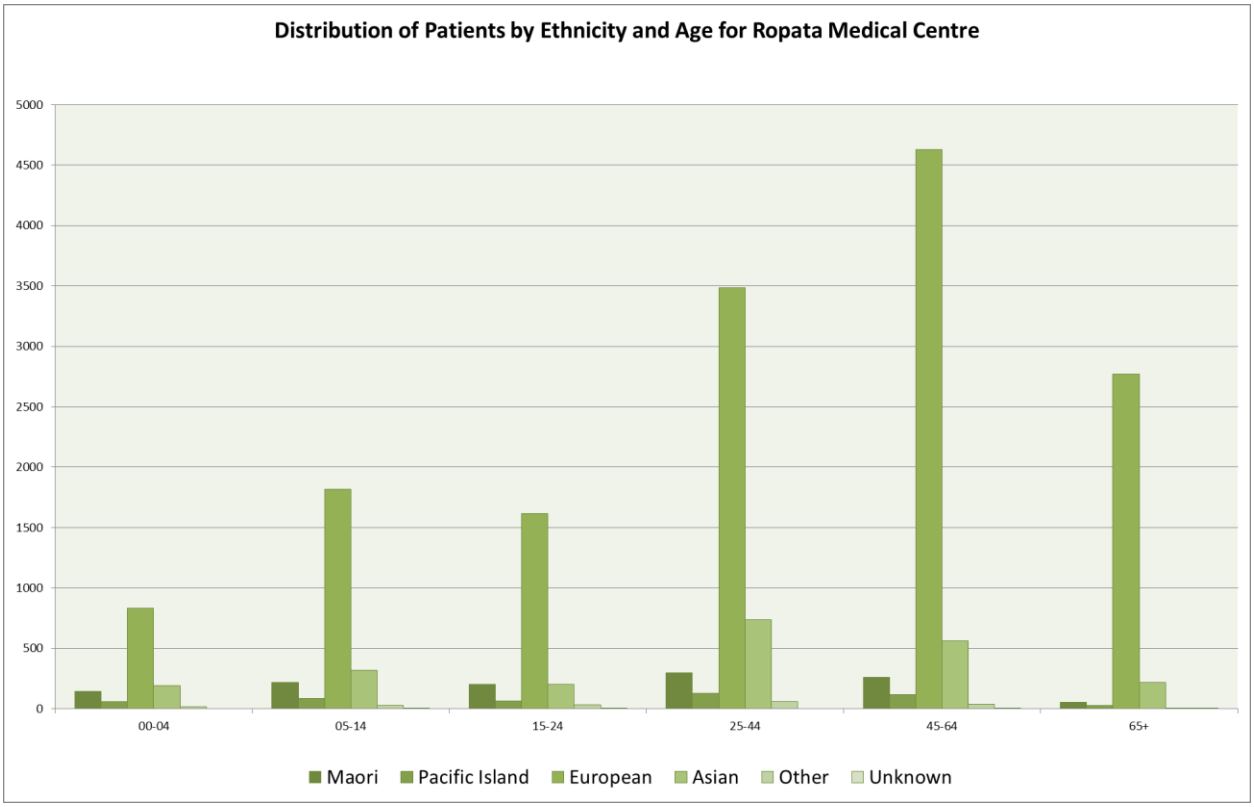
Proportion for Maori and Pacific peoples have remained stable for a number of years, irrespective of register growth. However, we have seen a steady increase in our Asian population with an approximate increase of 305 new patients in the last 12 months. Bringing new and fresh challenges to the practice around language barriers, understanding of culture and practice and medical terminology are just part of the growing list.

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 2016 to 30th June 2017.

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".**
We have a new team at Ropata with a Practice Manager who commenced on the 4th April 2016, a Nurse Manager who commenced on 11th April 2016 and an RN that commenced on 4th April 2016. We also have three RN's that have been part of the team for less than twelve months and we are in the middle of recruiting three new RN's. The new team is committed to the delivery of patient focused primary care.



Focus for 2016-17

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.
6. To continue to reach out to our Maori and Pacific patients using experience gained while working in areas with a high health needs population.
7. Engage with our increasing Asian population by coming up with strategies focused around understanding individual cultures and practices.
8. We wish to explore ways of breaking down the language barriers for our diverse population.
9. There are many opportunities to work with and influence communities around education to health and in particular obesity.

Priorities for 2016/17

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
4. Make Ropata Medical part of the community through integration and involvement.
5. Increase availability to health practitioners through extra clinics for nurses.

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 2016/17

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	111,204
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	111,204
EXPENDITURE														
Wage nurses		9172	9172	9355	9355	9355	9355	9355	9355	9355	9355	9355	9355	111894
Wage admin		1,164	1,164	1,164	1,164	1,164	1,164	1,164	1,164	1,164	1,164	1,164	1,164	13,968
Motor vehicle		0	0	0	468	0		0	563	0	0	0	0	1,031
Other costs		0	0	0		0	0	0	0	0		0	0	0
Total Expenditure		10,336	10,336	10,519	10,987	10,519	10,519	10,519	11,082	10,519	10,519	10,519	10,519	126,893
Monthly Profit/Loss		-1,069	-1,069	-1,252	-1,720	-1,252	-1,252	-1,252	-1,815	-1,252	-1,252	-1,252	-1,252	
Year to Date Profit/Loss		-1,069	-2,138	-3,390	-5,110	-6,362	-7,614	-8,866	-10,681	-11,933	-13,185	-14,437	-15,689	**-15,689**

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	3667	3667	3667	3678	3678	3678	3663	3663	3663	44,019
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	3,667	3,667	3,667	3,678	3,678	3,678	3,663	3,663	3,663	44,019
EXPENDITURE														
Wages nurse		801	801	801	801	801	801	801	801	801	801	801	801	9612
Wages (Smoking Cessation Admin)		1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	12,096
Warfarin Education				27	27	27	0	0	27	0	0	0	0	
Pre-diabetes		216	135	68	216	81	135	81	135	81	216	135	135	1,283
Other costs		633	633	633	633	633	633	633	633	633	633	633	633	7,596
Total Expenditure		2,658	2,577	2,537	2,685	2,550	2,577	2,523	2,604	2,523	2,658	2,577	2,577	30,587
Monthly Profit/Loss		1,007	1,088	1,128	982	1,117	1,090	1,155	1,074	1,155	1,005	1,086	1,086	
Year to Date Profit/Loss		1,007	2,095	3,223	4,205	5,322	6,412	7,567	8,641	9,796	10,801	11,887	12,973	**13,432**

Under Spend 2016/17

The under spend in the Health Promotion budget will be used and accounted for with the new initiatives as outlined earlier. A lot of what we do and achieve is routine practice and to make significant changes and improvements to an already successful enterprise takes some time to adjust and understand.

The overspend in the SIA budget that will be absorbed by the business.

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

Adrian Tucker

- Primary Acute Care in the Hutt Valley. A working group examining acute care, particularly after hours services. The group includes Hutt Hospital Emergency department, the After Hours Medical centre and the general practices.

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)