KIMI HAUORA WAIRAU

ANNUAL REPORT

2023

CONNECTING COMMUNITIES FOR WELLBEING

Mountain Biking South Marlborough, Credit: *MarlboroughNZ*

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Marlborough Vineyards, Credit: *MarlboroughNZ*

CEO Report

After three years of evolving needs and responses to COVID-19, the transition to a business-as-usual model has taken place. The 2022 - 2023 period has therefore seen the health sector shift it's focus to continuing to address inequalities in healthcare and the new changes to the health reforms.

Māori and Pacific people are identified nationally and locally as priority demographics, often encountering additional barriers to healthcare. We will continue to support the direction of these changes and continue contributing to co-designing a new system with all of our partners, placing health equity and accessibility at its core.

The sustainability of general practices remains a challenge nationally. As a Primary Health Organisation, we aspire to expand and lead more initiatives that address access to health, particularly for those with the greatest health needs. We have supported the implementation of models such as Care Co-ordination, Integrated Primary Mental Health and Addictions and Hikitia, all of which improves access and outcomes through better management of routine and preventative care. A key milestone in this journey was achieved this year with the remaining two Marlborough practices adopting Hikitia, bringing Marlborough practices to 100% engagement with the model.

Practice care teams have also been bolstered by using Practice Plus, a virtual and telehealth service offered with extended operating hours. Extended care teams that include Clinical Pharmacists, Health Improvement Practitioners (HIP) and Health Coaches (HC) continue, offering improved access to care. We intend to expand on the initiatives we have implemented in primary care over the next 12 months, to include increasing community engagement with Iwi Partners and NGO's. We will further grow our comprehensive care teams, offering an even greater variety of pathways to care for patients, support and health literacy information on how best to navigate them.

Beth Tester
Chief Executive
Marlborough PHO

Tomorrow's future health workforce also needs planning for today. We again foster our community partnerships to engage and promote health careers at colleges, as well as making plans to offer healthcare apprenticeships across our healthcare partners, giving prospective health providers a taste of the work involved and the sense of reward for being part of a team sensitively caring for patient's health needs.

The rewards and successes realised through our initiatives immediately benefit patients with modern and increasingly accessible healthcare that keeps in step with the communities' evolving needs and priorities.

Thank you to our Board for their continued oversight and commitment to improve the health of our community. Thank you also to our dedicated team of staff who draw daily upon their wealth of health experience to serve and support the Marlborough community.

Together, we continue to work towards our vision;

"Tūhonotia te hapori kei te ora".

Board Chair Report

Having just come into the role in October 2022, my first eight months to the end of the financial year have been mainly around getting to know the people involved and learning about the key elements of what Marlborough PHO is doing and the best practice approach to what we can be doing for the wellbeing and health of Marlborough people.

My initial conclusions are that - while challenges are there to be faced with how future fit in with National Health Policies will work out- the needed core elements of good people, sound finances and good strategies are in place and augur well for the role the PHO will need to play in both the short term and long term for Marlborough.

We have an outstanding CEO in Beth Tester, augmented by a very good team of management and staff whose dedication to their roles is exemplary. While there are a couple of vacancies to fill on our governance team due to end of term retirements, we are confident we have the makings of a governance group to set excellent strategies for the PHO. Just as importantly, finances have been well managed and adequate reserves are in place to ensure that projects which will benefit the core strategies of our PHO will be able to be well financed.

Beth's CEO report covers the operational details of the past year and what challenges are ahead to continue to grow the services of providing Primary Health care for our people. The Financial report shows an excellent result with funds committed and earmarked for future key projects. For 2023-2024 and beyond, from a governance view, I believe our priorities are to ensure that our strategy is fit for purpose for our core expected roles, that we are conscious of having sufficient resources and practices to provide ongoing best possible primary health care for all Marlburians, and that we work appropriately with Marlborough Iwi to implement Hauora Māori Health Strategy.

Mark Peters
Board Chair
Marlborough PHO

While we are still working through how National Health Strategies from Te Whatu Ora and Te Aka Whai Ora will affect the existing operation and structure of Marlborough PHO, we are certain that there will be an important role for us in ongoing primary health care for our Marlborough people. We will continue to work towards fulfilling that role as best as possible.

"...the needed core elements of good people, sound finances and good strategies are in place and augur well for the role the PHO will need to play in both the short term and long term for Marlborough."

Clinical Governance Chair Report

Dr. Jordan Gibbs
Board Chair
Clinical Governance Group

The 2022-2023 period has remained a busy one for the Marlborough Primary Health Clinical Governance Group. Meetings have run frequently, overseeing a wide variety of oversights and interests. The flexible approaches and attitudes required to thrive in the last few years continue to drive the group's work, with well attended meetings being held regularly.

The Inbox Shrinking programme was a workflow improvement introduced to multiple Marlborough practices, with scope to refine and improve in-house to meet each practice's needs. Under the programme, inbox actions are shared more widely among the practice team, with urgent actions remaining the responsibility of the requesting clinician. Doing so has seen a marked improvement in the removal of unnecessary items in practice inboxes, improving patient experience and contributes to overall practice sustainability.

Further improvement opportunities for general practice sustainability were identified in the value of further broadening health provider disciplines that make up practice teams. There have been many sucesses over the last few years of the embedding of HIPs, HCs and Clinical Pharmacists in practices. Building upon this, the group discussed the additional benefit of further complimenting practice disciplines with knowledge pools such as Paramedics, Physiotherapists, Kaiāwhina and Social Workers.

Other areas of discussion and oversight have included:

- Marlborough practices, Urgent Care and Wairau Emergency Department signing up to practice Plus Telehealth Service.
- a new CVDRA dashboard coming online, improving visibility of CVRDA needs between practices and MPH.
- new ways of working with data being tied in to national priorities and directions.
- oversight of a continuous glucose monitoring project, due to conclude and present results in the coming months.
- forthcoming meeting between Clinical Governance Group, Practice Managers and practice owners to collaboratively troubleshoot how to open books at Marlborough practices, enabling more people to enrol who currently are unable to do so.

Whilst the challenges facing health are consistently present and constantly evolving, the Clinical Governance Group is well placed to remain ahead the curve in the coming years.

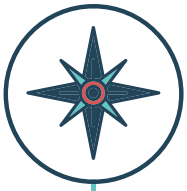
ABOUT US

Our Vision

Tūhonotia te hapori kei te ora

Connecting communities for wellbeing

Our Principles



People will be able to access and navigate the health system with ease.

Services will reduce inequality and meet the needs of Māori.

Services will be clinically safe and of high quality.

Innovation and experimentation will underpin all we do.

Customers will be involved in the design of services.

OUR VALUES

TRUST

Whakapono/
Rangatiratanga

Maintaining open and honest relationships

RESPECT

Wharaaro nui/
Manaakitanga

Embracing diversity, uniqueness and ideas

UNITY

Kotahitanga

Valuing strengths and skills

ACCOUNTABILITY

He mana tō te kupu

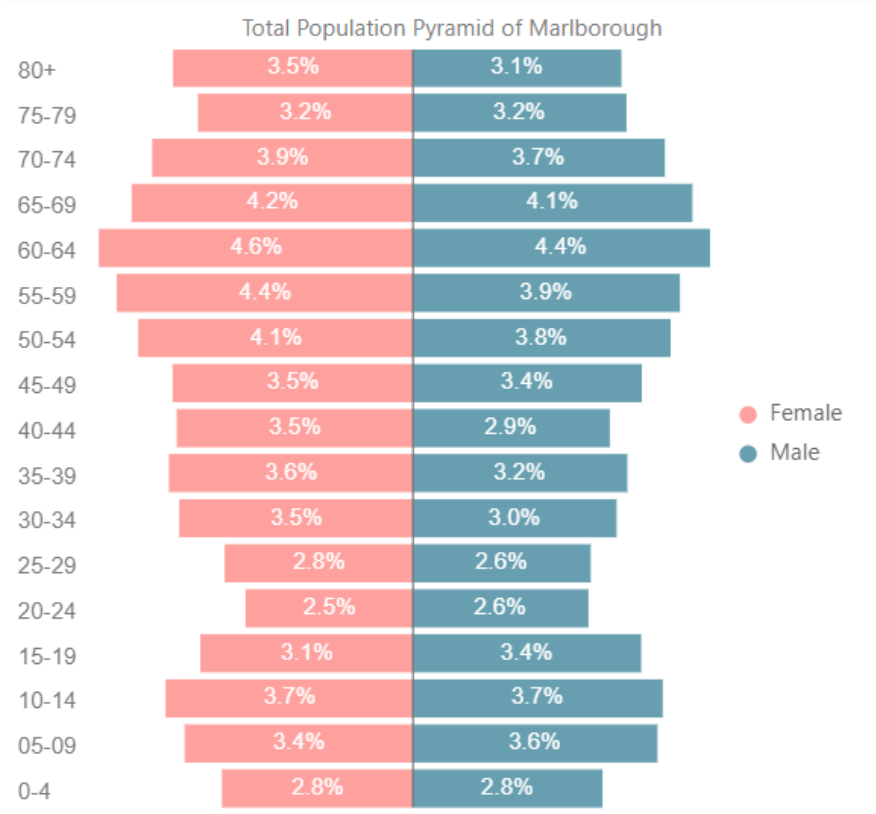
Working in a transparent and responsible manner

COURAGE

Ka tū te ihiihi/
Whakamanawanui/
Hautoa

Participating with confidence and enjoyment

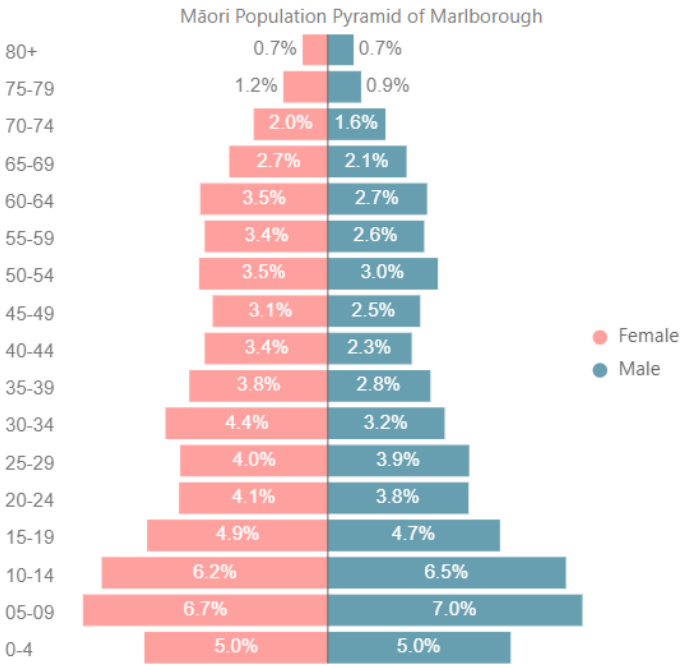
OUR COMMUNITY

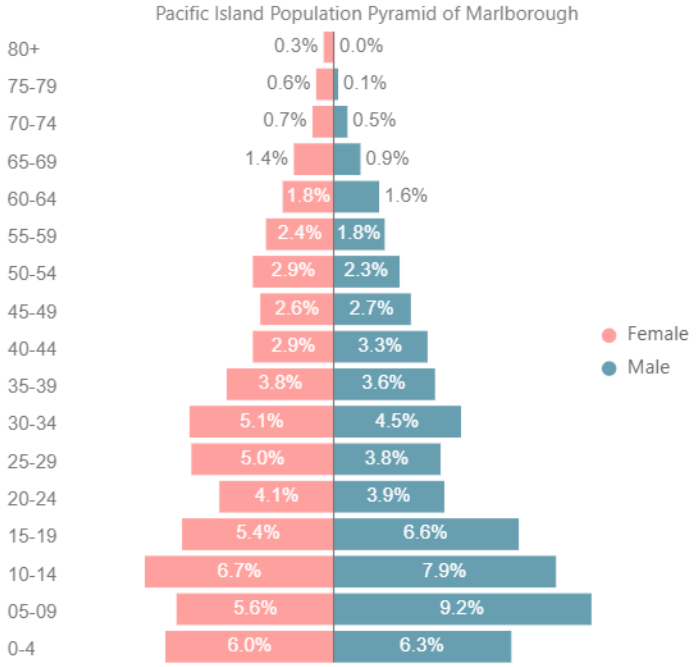


Population pyramids are useful to show how our total population is distributed by age and gender. Marlborough has an older population when compared to the country as a whole.

The population over 65 makes up 24.4% of the Marlborough enrolled population. This is larger than the national proportion of 17.3%. The age band 25-44 makes up 26.9% nationally but only 25.1% in Marlborough.

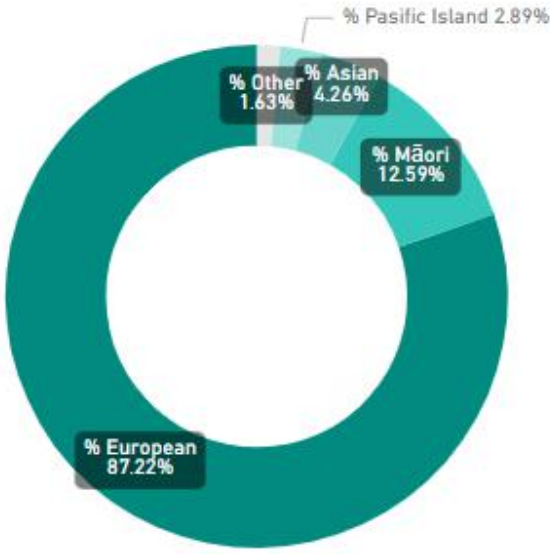
The Māori and Pacific populations of Marlborough are younger than the total population as a whole and as a result will have different health needs. It is important to be aware of these differing needs when considering equity in health service delivery.





OUR COMMUNITY

Total Ethnicity

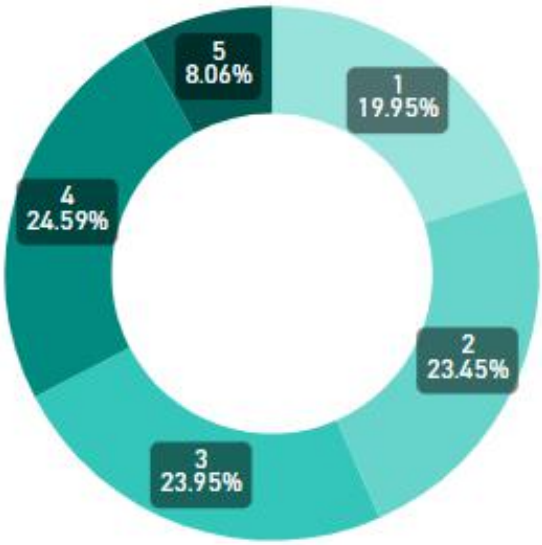


Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is self-perceived and people can belong to more than one ethnic group. The chart on the left shows the proportion of the enrolled population of Marlborough that identifies with five ethnic groupings. As people enrolled can identify with multiple ethnicities the total is greater than 100%.

At 87%, the enrolled Population of Marlborough has a higher proportion of people of European ethnicity than the 59% figure for New Zealand. There is a smaller proportion of people of Asian ethnicities in Marlborough 4.3% to 15.7% in the national enrolled population.

Marlborough PHO also share provision of healthcare for around 3000 workers from the Pacific Islands who are unable to be enrolled as they are employed under the Recognised Seasonal Employer scheme.

Deprivation Quintile



The deprivation index uses 9 variables from census data to measure the level of deprivation broken down by small areas. People living in more deprived areas are more vulnerable to poor health outcomes. The most deprived areas are in quintile 5, the least deprived in quintile 1.

Marlborough's enrolled population deprivation profile also differs to the the country as a whole.

In Marlborough, 8.1% of the enrolled population are in the fifth quintile for deprivation. The New Zealand enrolled population is at 18.5%.

Marlborough has a larger proportion in the fourth and third quintiles with 48.5% falling in these two categories versus 37.7% nationally. The top two quintiles are similar to the national averages.

FORMER REFUGEES

Supporting New Zealand's humanitarian effort - Former Refugees Accessing Health Services

In early 2019, central Government announced that Blenheim would join Whanganui, Levin, Masterton and Timaru as new host towns for refugee resettlement under the Refugee Quota Programme. The programme seeks to settle a fixed number of refugees (currently 1500 per year) throughout the host locations.

In July 2020, the first family was welcomed to Blenheim, originating from Colombia, marking the beginning of a transformative journey. Building upon this, efforts expanded in October 2022 as support was extended to individuals from the Rohingya community.

During 2022 - 2023, Marlborough has welcomed a vibrant group of 56 Rohingya individuals and 21 Colombian individuals. This merging of cultures and narratives has significantly enriched the fabric of our community.

Upon arrival into NZ and prior to coming to Marlborough, families typically spend five weeks at Te Āhuru Mōwai o Aotearoa – Māngere Refugee Resettlement Centre before joining the Marlborough region. During the time at the centre, they receive comprehensive medical evaluations and invaluable orientation sessions, acquainting them with the intricacies of New Zealand's systems and lifestyle. This preparatory phase provides the essential knowledge and resources as they embark on their new journey within NZ communities.

Upon a family's arrival in Blenheim, the foremost health priority is to facilitate their access to suitable medical care, MPH supports by co-ordinating enrolment in practices. As former refugee families often lack transportation, every effort is made to identify a medical practice near their residence. During the initial six months of their settlement, Red Cross volunteers provide valuable assistance, ensuring a smoother transition.

During this period, the family receives their first consultation with a GP and a Practice Nurse. This comprehensive health check serves to update their immunisations, which sill have already commenced during their time in Māngere. Beyond the initial appointments, former refugee families receive funding for practice consultations and certain medications for the first two years from their arrival in Marlborough.

"The programme wraps support around families looking to create a new life here in New Zealand by enabling them to access to affordable healthcare."

Karol Galleguillos, Cross Cultural Refugee Navigator

FORMER REFUGEES

During 2022 - 2023,

77

new individuals settled in Marlborough region.

96

individuals active in 2 year programme.

69

refugee enrollments at practices.

98%

of Former Refugees accessing healthcare through the programme.

Interpreters are used during these appointments for effective communication and the medical practices display commendable dedication whilst attending to the needs of these families. It remains important to acknowledge the challenges have been encountered throughout this journey. A significant hurdle involves the language barrier when interacting with Rohingya community members. The lack of in-person interpreters, coupled with a considerable number of illiterate and health illiterate families, underscores the communication difficulties and the importance of mutual understanding.

Despite these challenges, our commitment to nurturing a welcoming and inclusive environment remains steadfast. We are dedicated to identifying innovative solutions that bridge these gaps, ensuring every member of our diverse community can genuinely feel at home and thrive.

This ongoing effort underscores our commitment to providing a secure and supportive environment for individuals seeking refuge and a fresh start in our community.

HIKITIA

Extending Health Care Home to Strengthen Family Practice in Marlborough

Hikitia is an extension of the sucessful Health Care Home model, which supports the practices journey on prioritising equitable outcomes for their patients and adapting flexibly in how they meet their patient needs.

Within Hikitia, our practice teams are made up of a wider selection of health professionals and team members engage with patients through a variety of channels, rather than exclusively in person and onsite at the practice.

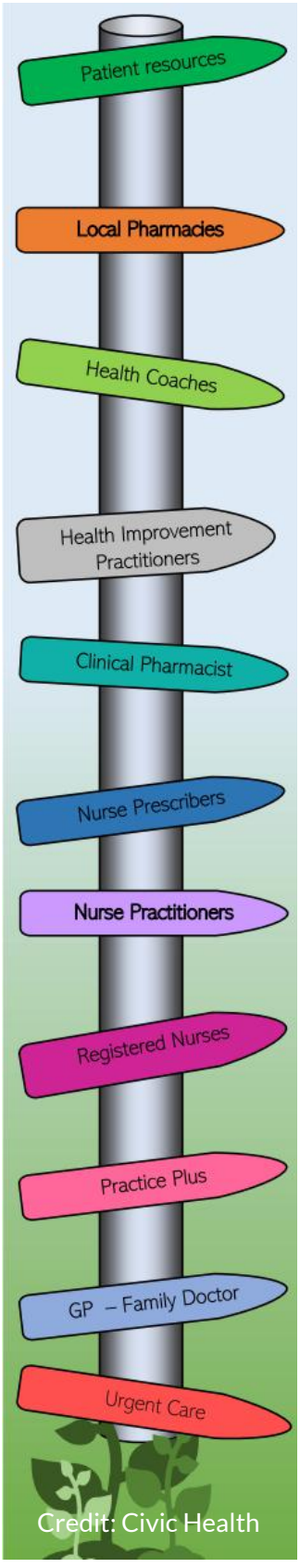
During 2022 - 2023, Marlborough practices achieved the important milestone of the number engaging in Hikitia increasing from 80% to 100%. The benefits to patients and practices include:

- All practices offering a patient portal for their enrolled population.
- Rollout of telehealth virtual general practice consultations via Practice Plus to our enrolled and unenrolled population.
- Introduction of informative signage and patient education materials, highlighting the effectiveness of consulting the appropriate professional at the right time.
- Practice teams implementing quality improvement projects that address health inequities within their enrolled population.
- The broadening of healthcare teams within practices, resulting in a wider array of healthcare professionals available to meet patient's healthcare needs.

Health education initiatives such as the Know the Right Professional signpost (right) are being utilised in primary care to improve pathways to healthcare provision. The aim is to educate the population about the breadth of health professionals available to patients rather than the systemic approach of needing an appointment with a GP.

"Extended practice teams offer more ways to meet a patients health needs, the benefit of which is passed immediately onto the patient themselves."

Renee Ward, Programme Development Facilitator

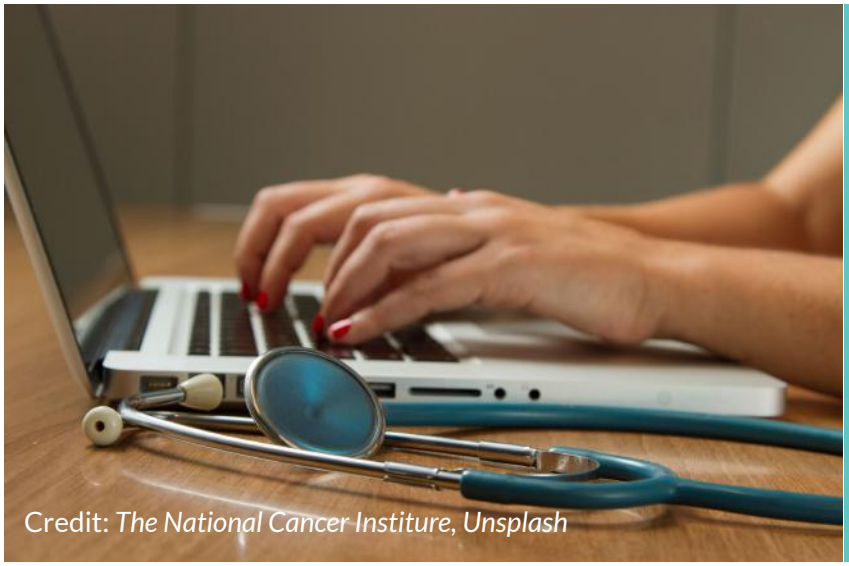


Credit: Civic Health

HIKITIA

With patient education information and pharmacies providing initial advice and guidance for lower severity health issues, the in-practice team is better placed to work with the more severe issues via a triage process. Practice Plus extends care beyond the internal practice resources offering an equally high standard both during practice opening hours and into the evenings.

The broadening of practice team disciplines is apparent with HIPs, HCs and Clinical Pharmacists being embedded into Marlborough practices. Further expansion of practice team disciplines is planned with the future inclusion of Paramedics, Physiotherapists, Kaiāwhina, and Social Workers.



Credit: *The National Cancer Institure, Unsplash*

23,331

patients registered for online practice portals.

75%

of registered patients actively using online portals.

Wider and deeper teams at practices are able to further increase access to healthcare for patients in need by offering appointments in practice, virtual consults and in-person appointments at patient's homes, delivering comprehensive and holistic healthcare services.

CARE CO-ORDINATION

Supporting patient voices in complex care

People with complex health conditions often require support and care from multiple health and care providers simultaneously. For some, the greater the complexity of their health, the greater the likelihood that multiple providers and agencies will be part of their care team. The aim of Care Co-ordination is to facilitate high quality care coordination for people and whānau with the greatest complexity of care needs, receiving care from multiple providers.

Hei Pa Harakeke, nurturing care in the first 1,000 days, supporting parents to develop healthy, nurturing positive relationships with their babies enabled through linking community teams and health care providers to better support pēpi, whānau and hapū mama. During 2023, Hei Pa Harakeke transitioned to Care Co-ordination and under Te Pae Tata, inclusion is being expanded to the first 2,000 days.

For all age ranges, Care Co-ordination fosters a person/whānau-centred approach empowering people and their whānau to be partners in health.

"He really appreciated the plan and the clarity it gave him."

Whānau voice

"She thought nobody was listening to her and now she knows that the team care about her."

Whānau voice

"Care Co-ordination is a fantastic forum to enable people to be on the same page and to enable future communication"

Health provider and Care Co-ordination participant

Where a Care Co-ordination meeting is required, the person and their wider health team are brought together, supporting them to work together to develop a care plan that reflects the goals of the person and their whānau.

Care Co-ordination also promotes health and wellbeing outcomes for people by strengthening links between services involved in their care. It enables health providers and community services to work together across organisations and services.

During the last year, the Care Co-ordination team have sought to continuously improve the service offered, including information and guidance materials for people and whānau and actively identifying those with complex needs that could benefit from the framework Care Co-ordination offers. Doing so further strengthens their relationships with providers and services to grow Care Co-ordination across collaborative health networks.

Care Co-ordination continues to evolve in response to the changing health system, working towards initiatives to support the priority areas and themes of national strategies such as Pae Ora and Te Pae Tata, as well as the needs of our community.

PRIMARY MENTAL HEALTH

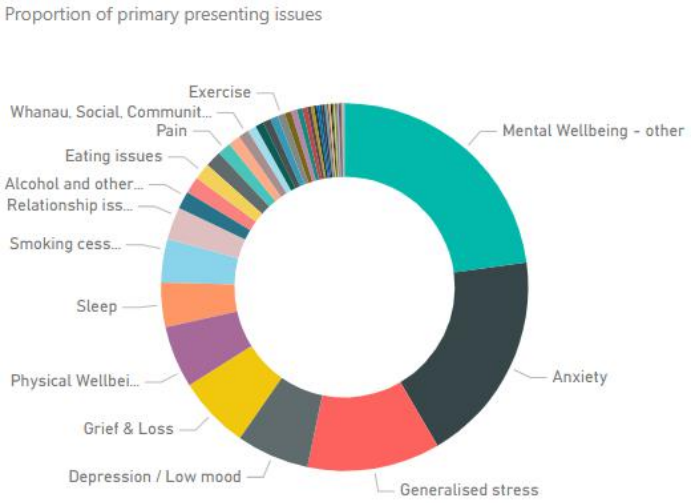
Open access models to meet Primary Mental Health needs in Marlborough

The Primary Mental Health Team is responsible for delivering the Integrate Primary Mental Health and Additions (IPMHA) and Primary Mental Health (PMH) services. Complementing the existing services, the Youth Primary Mental Health and Additions (YPMHA) service will soon also be delivered by the team.

The **Integrated Mental Health and Addictions** service increases accessibility of mental health clinicians to clients by embedding those clinicians in practices. The referral process is a 'warm' handover, where clients are introduced in-person to clinicians by other health providers within the practice team. Referrals by community health care teams or via self-referral can also take place.

The embedded clinicians used in this model fall into two categories; Health Improvement Practitioners (HIPs) and Health Coaches (HCs). HIPs are registered health professionals, typically working one-to-one with clients regarding 'mild' physical and mental health issues, offering referrals and connections where appropriate. HCs are trained support workers, working individually and in group settings, often focussing on establishing and supporting plans to wrap around clients individual long term health conditions.

Whilst the IPMHA roles work with both physical and mental health, two thirds of the primary presenting problems are related to mental health. Feedback received from practices as part of an evaluation process earlier this year was excellent. We attribute this to the consistent staffing as the many of the team of six of Marlborough HIPs came on board when the programme originally launched.



Meanwhile, the two HCs have displayed flexible approaches as all parties work through the challenges for HCs to be onsite at all practices due to the logistics of physical space. The staff and the model has continued to adapt with HCs offering a mixture of appointments in practice and from the Health Hub in Blenheim.

The **Primary Mental Health** clinicians provide between four and six Brief Interventions Counselling sessions for those experiencing 'moderate' difficulties. Issues addressed include examples such as anxiety, depression and grief. Three clinicians provide the mainstay of this service, with the opportunity and funding to create Packages of Care in certain situations, whereby a Health Psychologist is contracted for a fixed number of sessions.

In addition to individual work, cross-service skill sharing is demonstrated during an ongoing drop-in course is run by a PMH Clinician and a HC, offering relaxation skills group to teach clients a range of techniques to reduce tension, stress, and anxiety.

PRIMARY MENTAL HEALTH

The service provided by the PMH Clinicians is well utilised and a popular referral pathway. To best manage availability and demand, suitable work is referred onwards to HIPs and the short-term use of contracted Counsellors has helped to alleviate the pressure on waiting times. Going forwards, additional Counselling resource is being made available to further bolster the options for Packages of Care that PMH Clinicians are able to draw upon for improved patient care.

During the 2022 - 2023 period, planning has been underway for the rollout of a new **Youth Primary Mental Health and Addictions (YPMHA)** service. The service will target young people aged 12 to 24 years old, with mild to moderate mental health and wellbeing issues. These areas are receiving additional focus and funding at a national level as the ages of 12-24 are a time of rapid change and development and are recognised as being a higher risk time for the development of mental health concerns. An important component of our planning this year has been our actively engaged with the Youth Forum, a group of key agencies with a strong focus on youth.

The YPMHA service will be delivered in partnership with Health Action Trust and Nelson Bays Primary Health Organisation. It is again our attention to strong partnerships with local bodies that enables the successful delivery of our current and future programmes. We are looking forward to rolling out this much needed support for young people.

3059

HIP sessions delivered in 2022 - 2023.

470

HC sessions delivered in 2022 - 2023.

1939

Primary Health Clinician sessions delivered in 2022 - 2023.

SELF-MANAGEMENT

Empowering Patients Through Education

Our Self-Management Education Team provides and co-ordinates education to clients managing long term health needs such as,

- Pulmonary Rehabilitation
- Chronic Pain
- Cardiac/Healthy Heart
- Type II Diabetes
- Pre-Diabetes

The team informs clients and their whānau via workshops, group sessions, individual sessions and community education.

Through discussion of risk factors, complication prevention and lifestyle choices, course attendees are given the tools to better self-manage.

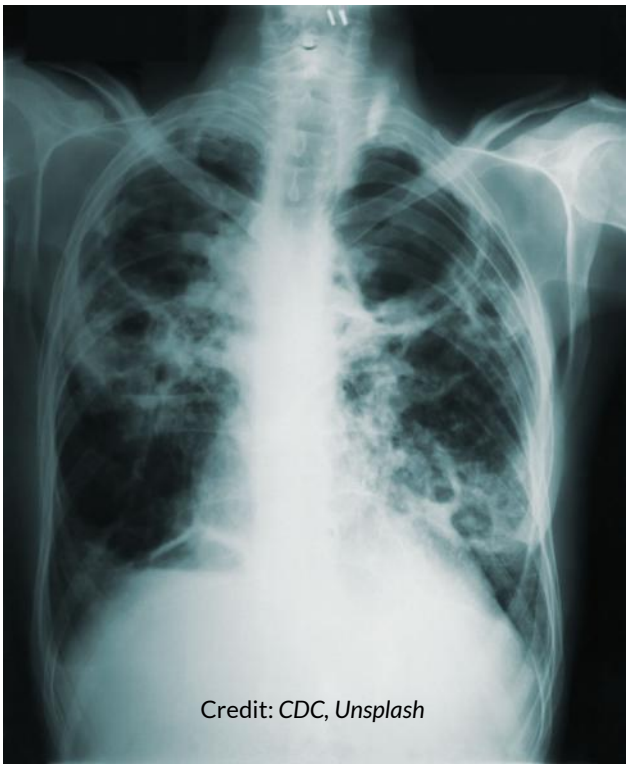
Consequently, their self-confidence is improved, they are better able to improve their own accountability and they are empowered to make healthier choices, delaying or preventing longer term health issues.

"I am fitter and lighter now and can do much more without getting out of breath. Thanks to the course, I am more confident with what to do if I think I am unwell."

Pumonary Re-habilitation Course Attendee

Pulmonary Rehabilitation has undergone a review and overhaul including content such as breathing techniques and inhaler education. Consequently the new six-week course is run twice as frequently with four courses per year, notably shortening the time from referral to the next available course dates.

One of the real successes from the last year are the smaller group sizes allowing for more interactive sessions and stronger bonds between course attendees to develop, improving the experience for all, as well as reducing waiting times and widening course accessibility to prospective attendees.



Credit: *CDC, Unsplash*

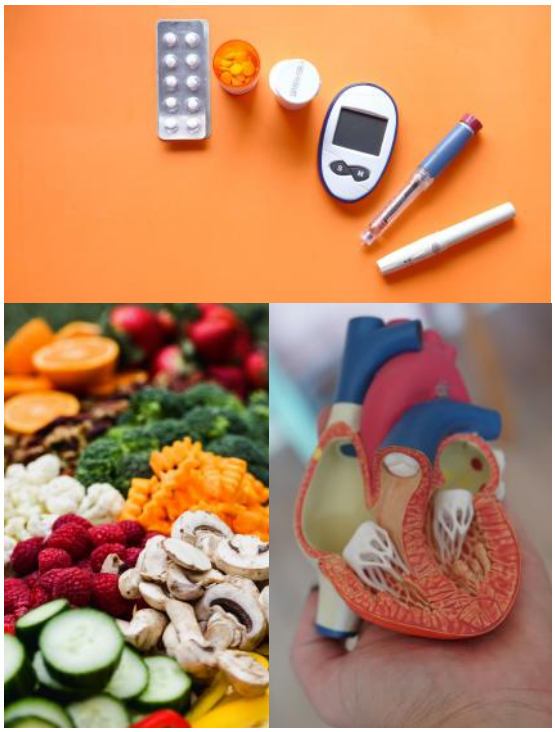
SELF-MANAGEMENT

Chronic Pain programme has been streamlined into three sessions, whilst maintaining the emphasis on the biological, psychological and social factors impacting people with chronic pain. The workshop sessions drew upon MPH's health partnerships with presentations by Physiotherapists, Community Dietitians and Primary Mental Health Clinicians.

Participants gained an understanding of the difference between acute and chronic pain, the importance and benefits of activity pacing and graded exercise therapy, and the benefits of mindfulness and self-care tools. In addition, the emotional and mental reactions to pain continued to be explored.

Our **Cardiac/Healthy Heart** workshop continued as a three-day workshop with community health providers from a range of specialties including Cardiac Clinical Nursing, Community Pharmacist, a New Zealand Red Cross CORE Advanced Instructor, Community Dietitians and Green Prescription programme staff. Patients were invited to attend with whānau and material covered heart disease risk factors and complications and self-management strategies for gaining a healthier lifestyle with healthy eating, healthy activity and well-being. The combination of these set them in good stead to improve their heart health and reduce complications from heart disease.

Along with the Cardiac Self-Management Programme, a three-day workshop is delivered tackling living with **Type 2 Diabetes**. Insight is taken from the Diabetes Clinical Nurse Specialists, with participants coming to learn about the complications associated with Type 2 Diabetes and the latest medications and technology being used to treat Type 2 Diabetes was enhanced. Self-care and management is emphasised by learning strategies for healthier eating and activities to encourage healthier lifestyle changes from MPH staff.



Credit: *Towfiqu Barbhuiya, Robina Weermeijer and Nathan Dumlao, Unsplash*

Pre-Diabetes is a one-day workshop where participants learn about what it means to have Pre-Diabetes and how learning to eat healthier and lead active lifestyles can delay the development of Type 2 Diabetes and the associated risk of complications. MPH staff are called upon for their expertise in self-management tools, such as goal setting and provide information on healthy activities and nutrition. Participants especially enjoy having the myths of reading food labels 'de-mystified'.

OPERATIONAL SNAPSHOT

74.4%

of patients are up to date with breast screening.

Māori	67.9%
Pacific	62.9%

78.1%

of cardiovascular checks done for at risk patients.

Māori	74.4%
Pacific	71.3%

77.1%

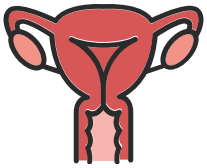
of diabetes patients have had an annual review.

Māori	71.9%
Pacific	74.4%

83.1%

of smokers have been offered advice how to quit

Māori	79.7%
Pacific	87.3%



73.4%

of people with a cervix are up to date with screening.

Māori	67.2%
Pacific	64.7%

86.6%

of 8 month old babies fully vaccinated.

Māori	74.5%
Pacific	85.7%

89.6%

of 2 year old children fully vaccinated.

Māori	86.0%
Pacific	84.0%

64.8%

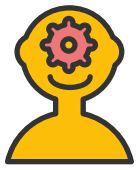
of 65+ year old given influenza vaccine.

Māori	50.6%
Pacific	63.3%

1939

Primary Mental Health consultations.

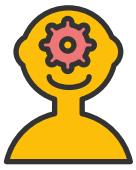
Māori	223
Pacific	57



3059

HIP consultations.

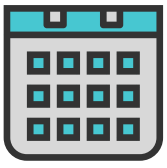
Māori	502
Pacific	51



470

Health Coach consultations.

Māori	55
Pacific	10



98

patients referred for care co-ordination.

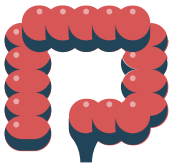
Māori	24
Pacific	2

OPERATIONAL SNAPSHOT

57

Advance Care Plans created.

Māori	5
Pacific	0



63

positive FIT bowel cancer screening cases managed.

Māori	9
Pacific	2

795

people receiving Options for Care treatments.

Māori	113
Pacific	26

349

people receiving skin lesion removal procedures

Māori	10
Pacific	0

10356

patients receiving Care Plus treatment.

Māori	1266
Pacific	223

489

people provided with emergency contraception

Māori	92
Pacific	9

709

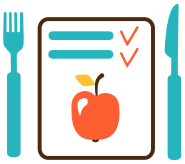
podiatry treatments funded.

Māori	84
Pacific	10

442

people referred to green prescription programme.

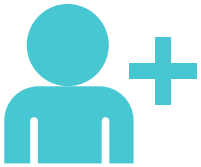
Māori	80
Pacific	25



351

initial consults with community dieticians.

Māori	39
Pacific	12



69

refugees enrolled at practices.

MPH delivers a broad range of services and initiatives, often working in partnership with a number of other health care providers, community trusts and NGOs. Whilst programme engagement numbers decreased during and in the years following COVID-19, numbers across all programmes are recovering well and the level of programme engagement approaches pre-COVID levels. We have increased staffing to extend the benefits delivered by these programmes across the community.

STATEMENT OF FINANCIAL PERFORMANCE

Summary Statement of Financial Performance

Kimi Hauora Wairau Marlborough Primary Health Organisation Trust

For the 12 months ended 30 June 2023

	Actual	Budget	Last Year
Funds Received			
Health NZ Funding	12,599,996	12,761,320	12,275,418
DHB Programme Funding	5,692,502	3,271,314	6,228,104
Other Income	(91,295)	972,086	1,553,072
Total Funds Received	**18,201,203**	**17,004,720**	**20,056,594**
Payments to Health Providers			
General Practice Payments	13,052,527	12,124,115	13,592,852
Provider Expenses	1,221,441	772,342	1,255,345
Health Care Homes	20,000	57,000	80,974
Total Payments to Health Providers	**14,293,968**	**12,953,457**	**14,929,171**
Net Income	**3,907,235**	**4,051,263**	**5,127,423**
Operating Expenses			
Staff Expenses	2,877,788	2,860,396	3,361,872
Donation Expense	10,462	450	509,475
IT, Software & Reporting	210,588	186,715	187,421
Programme Expenses/Resources	79,889	72,419	153,967
Contribution to Services	0	0	45,140
All Other Operating Expenses	728,508	931,283	869,547
Total Operating Expenses	**3,907,235**	**4,051,263**	**5,127,423**
Total Surplus/(Deficit)	**0**	**0**	**0**

At year end, unutilised funding is transferred out of the Income Statement, to be taken up in the following year.