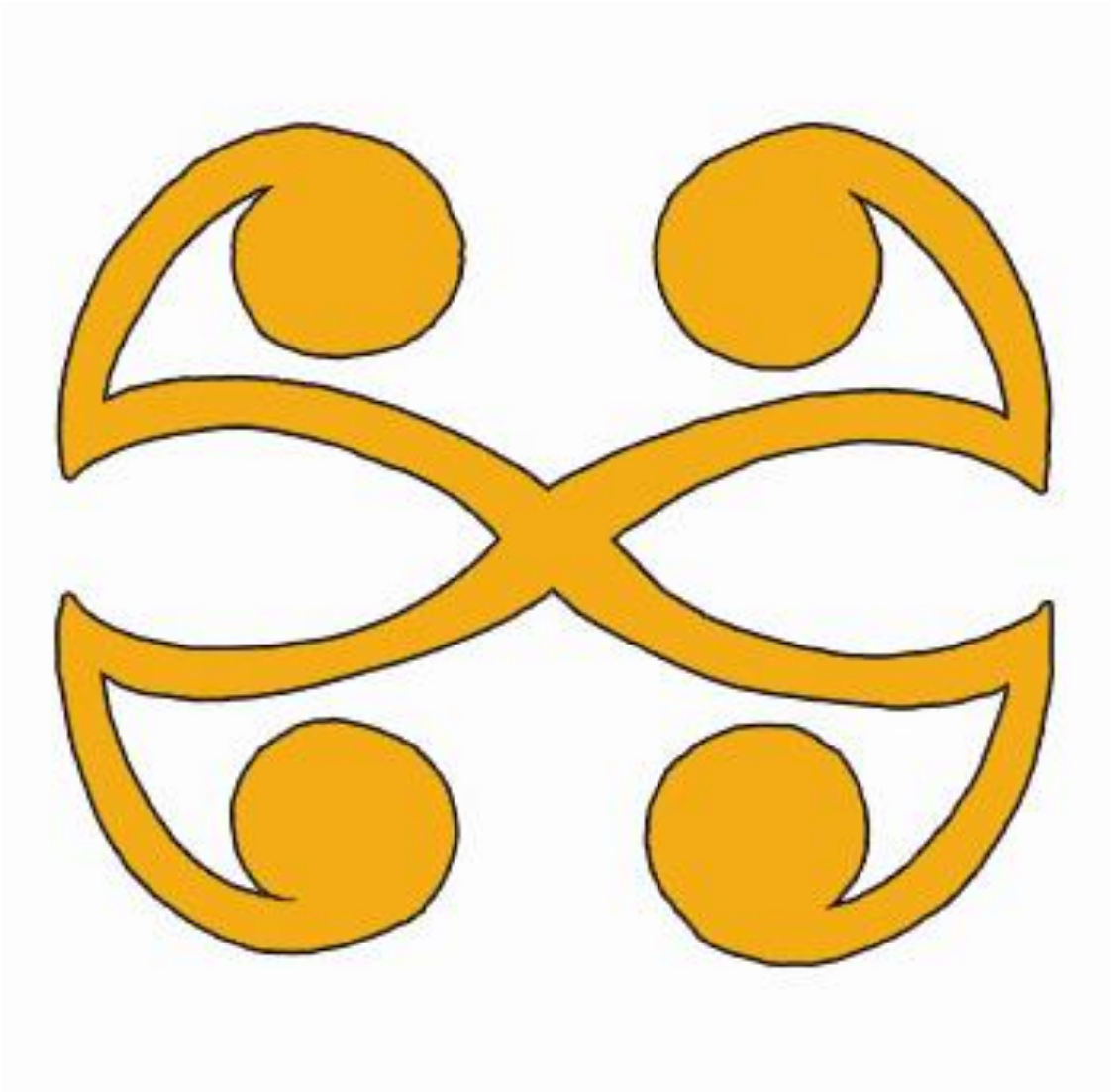
NEWTOWN UNION HEALTH SERVICE

2012-2013
ANNUAL REPORT



CONTENTS

SECTION ONE

Newtown Union Health Service Policy Board and Staff

Policy Board

Chairperson	James Sleep
Treasurer	Gamini Settinayake (resigned May 2013)
	Julie Lamb
Secretary	Fiona Osten
Kaumatua	Te Urikore (Julius) Waenga
Staff (clinical) Representatives	Pauline Horrill
	Vivienne Coppell (resigned Nov 2012)
	Dianne Theobald
	Kieran Monaghan (resigned May 2013)
Maori Rōpū Representative	Tina Bennett
Union Representative	James Sleep,
	Daele O'Connor
Community Representatives	Wilson Toma
	Julie Lamb
	Jeremy Rose
	Eileen Brown

Staff

Administration Team	Fiona Osten (Manager), Maribeth Major (Operations Coordinator), Kareena Bryant (Senior Administrator), Tunisia Pohatu (Clinical Administrator), Serena Moran (Clinical and Quality Service Coordinator)
Allied Health	Stefanie Döbl (Social Worker), Flora Toma (Interpreter)
GP Team	Vivienne Coppell (Team Leader), Annie Judkins, Jonathan Kennedy, Tin Maung Maung, Pauline Horrill, Andy O'Grady, Katrina Harper, Nikki Turner, Ben Gray
Nurse Team	Dianne Theobald (Team leader), Fou Etuale, Bryony Hales, Maureen McKillop, Kieran Monaghan, Louise French, Joanne Forsyth, Mary Tohill, Kathy Clarke, Asha Clark, Karen Fry, Sherryn Strickland
Reception Team	Pito Toeleiu, Seborah Hanipale, Debbie McGill, Josie Bain, Judith McCann, Fusako Kobayashi, Awhina Haerewa, Penny Tyler
Inner City Project	Tina Bennett (Team Leader), Janine Hauraki (Administrator), Stephen Jardine, Sonia Smith, Warren Doughty, Willie Mailei

SECTION TWO

Chairperson's Report

Newtown Union Health was opened in 1987 by the union movement to provide affordable, accessible quality primary health care for low income Wellingtonians.

The values that drove the visionary organisations and individuals, to set up NUHS remain our driving force.

We aim to provide a comprehensive primary health service, which looks at the whole picture to get to the root causes of health problems, with the objective of reducing health inequalities experienced by low income communities.

Our contribution to the story of growing inequality

Our kaupapa is the foundation of our service, a service that has faced funding cuts and funding uncertainly for nearly two years. It is a reality that these cuts have undermined our internationally recognised and comprehensive health service. These cuts have been tough for Newtown Union Health, and other primary health services like our sister organisation Hutt Union Health. We have been forced to make tough calls which have led to service cuts. These funding cuts have been illustrated in Max Rashbrooke's book 'Inequality – A New Zealand Crisis' and Professor Don Matheson's report on CCDHB's funding cuts to primary health care. In addition, NUHS support the nationwide emergence of a community movement for a Living Wage to help reduce poverty and

It is our communities, many of which have high health needs, that are receiving the least health spend in New Zealand. This has meant that the funding pressures of the last 24 months, which have resulted in increased visiting fees at NUHS and service cuts, have made this situation worse and contributed to growing inequality.

Many of our communities are voiceless. That's why it's important that services like ours, including leaders in the health sector and community, are able to play an active role in advocacy. We do this through promoting the success of our model. We know that comprehensive primary health services like Newtown Union Health Service, when properly resourced, are proven to reduce health inequalities.

Getting back on our feet

It has been a year of consolidating and getting back on our feet after the funding cuts of 2011-2012, to ensure we are providing the highest quality service possible within our reduced means.

At the start of the year we were budgeting a deficit, however are now financially steady. It's testament to the prudent financial management of Manager Fiona Osten, our Financial Controller Giordano Rigutto and the rest of the team that we are now able to report a small surplus.

Strengthening our governance

Alongside our focus on getting back on our feet, the Board has been working to strengthen decision making. This means improving the skills, knowledge and focus of the Board to allow us to make good decisions in the interest of the service and community.

A big priority for the year was developing the first NUHS operational plan since 2009. The operational plan now sets out the direction for our service through to the end of the financial year in July 2014, where it will be renewed based on our strategic goals. While this may seem basic, it is an important advancement for our service and has provided greater focus for the months ahead.

Building our presence in the community

Strengthening our role in our community has been the third focus of the Board. On a day to day basis our service is grounded and engaged with our communities through our core work; however, it was the strongest piece of feedback from the last AGM that NUHS could have more presence in the South Wellington community.

Going Forward
In 2014 NUHS will hold public forums on issues of importance to the communities of South Wellington, this could range from public information and health promotion forums, through to discussion and debate on issues such a inequality. Alongside this is our commitment to build community networks, with the initial plan to set up a NUHS cycling group. We will also be creating space for our community to provide feedback and contribute to the improvement of the service. I encourage you to keep an eye out for these activities and get involved.

Thank you
I want to acknowledge our fantastic staff who keep the service running strong day to day. The skills, energy and initiative that each and every staff member brings to our service is what keeps us moving.

I want to also acknowledge the Board who have worked well together for the last 12 months and stayed focused right to the end. Thanks also to Kareena Bryant for the top notch support she has provided the Board, helping to keep us on top of everything.

A huge thank you must go to our very talented Manager Fiona Osten. The Board comes to our AGM with the upmost confidence, respect and gratitude for the leadership that Fiona has and will continue to provide our service. Particular recognition must be given for her leadership of NUHS through some of our hardest times in the last couple of years, and for keeping the service financially steady. It has been an absolute privilege and delight to work with Fiona across the year.

As we head into a new Board year we must ensure our kaupapa weaves through every decision we make. We are part of a bigger story of tackling inequality in our communities. The last twenty-four months has tested our resilience, but we come out of this period and into 2014 with stronger will and determination to deliver quality, affordable and accessible primary health care to the community of South Wellington.

James Sleep
Chairperson NUHS Policy Board

Manager's Report

2013 has been an interesting and challenging year where the focus of the NUHS team has been one of consolidation.

Over the last decade, the work of the clinical team has continued to develop and expand as we respond to the growing needs of the community and the recognised need to provide services closer to where people live and in the most appropriate setting. To do this work safely and effectively, NUHS identified the need to dedicate a role to provide clinical quality leadership based on a continuous quality improvement ethos. Therefore, NUHS established a new Clinical and Service Quality Coordinator role this year with responsibility for monitoring and maintaining standards relating to clinical practice, quality, and quality improvement activities.

April was the final month of the NUHS Midwifery Service. The lead-up to the closure brought a time of uncertainty for the pregnant women of NUHS but through established working relationships with a local independent midwives NUHS holds midwifery clinics 2 days a week at the Newtown clinic, where pregnant women continue to have access to the social worker, interpreting services, transport and the medication subsidy as required.

Following the funding cuts of last year, it has been particularly important for the service to concentrate on maximising our income. The reception, administration and financial teams have continued to review and improve the collection of information for future funding initiatives and overdue claims, in particular outstanding ACC claim payments.

A significant achievement this year was the recognition of the collaborative work of Stefanie Döbl, NUHS Social Worker, and Amy Ross, St Vincent de Paul Social Worker by the Capital & Coast DHB Quality Improvement Awards where they won a top award. Amy and Stefanie have worked closely together providing collaborative services for the Newtown community and it was exciting for us as a service to have this work acknowledged by peers and the funders.

I would like to take this opportunity to thank the staff for their commitment to NUHS and focus on the community we serve. The challenges of providing primary health care services from a community model within a tight fiscal environment is challenging and I acknowledge the hard work of every staff member for the support they offer me as the Manager. Although the sustainability of NUHS is reliant on funding, it is equally reliant on the people within the service and often the invisible work which helps provide value to the community..

I acknowledge and thank our Kaumatua Te Urikore (Julius) Waenga for his commitment and guidance to the service. I would also like to thank James Sleep, Chairperson and the NUHS Board for their support over the last 12 months.

I thank the wider community for their continued support and positive words of encouragement, which help to ensure NUHS remains part of the community for the years to come.

Fiona Osten
Manager

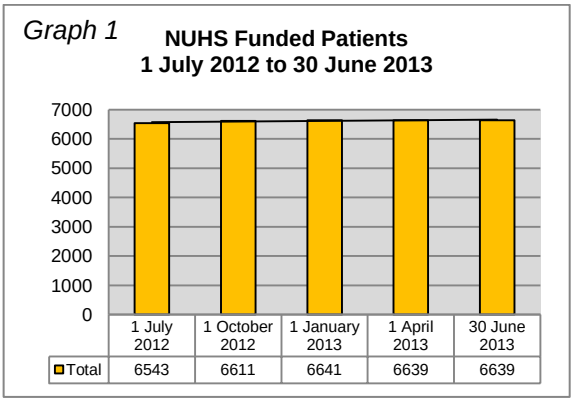
Patient Register Demographics Report

As expected we have seen less dramatic movement again this financial year in comparison to the previous Annual Report. The data analysed in this demographics report gives a snapshot of the NUHS patient register.

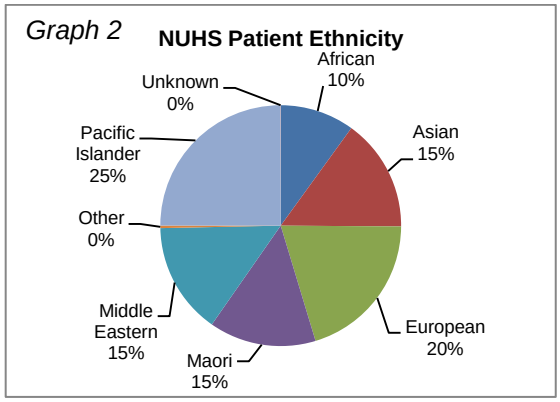
The Newtown Union Health Services patient register was 6.639 as at 30 June 2013. As expected, there has been an increase to the number of register patients, since NUHS re-opened enrolments.

The majority of registered patients are aged between 25 and 44 years old and 40% of our registered patients are Pacific Island and Maori.

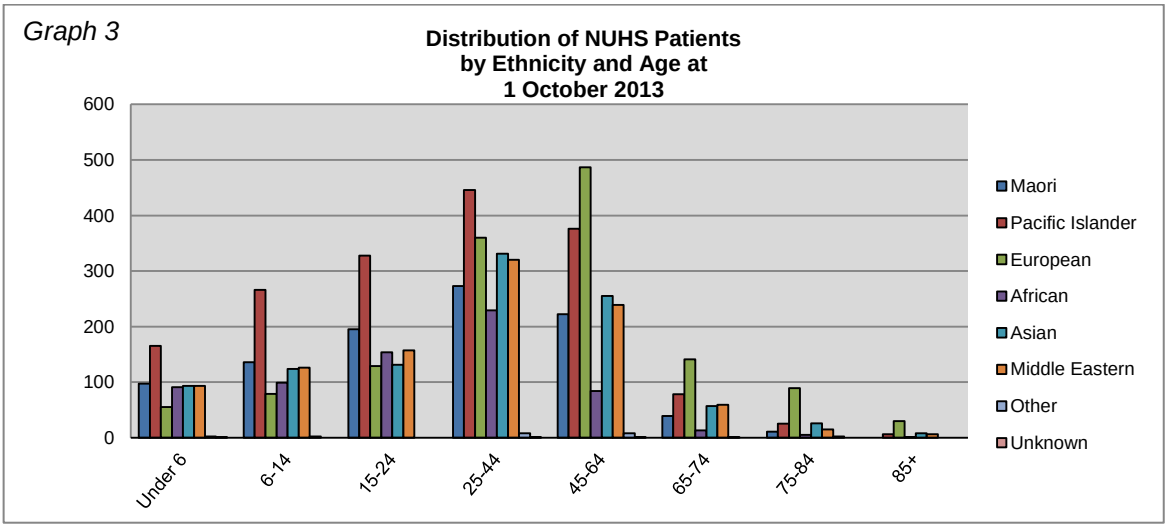
Graph 1



Graph 2

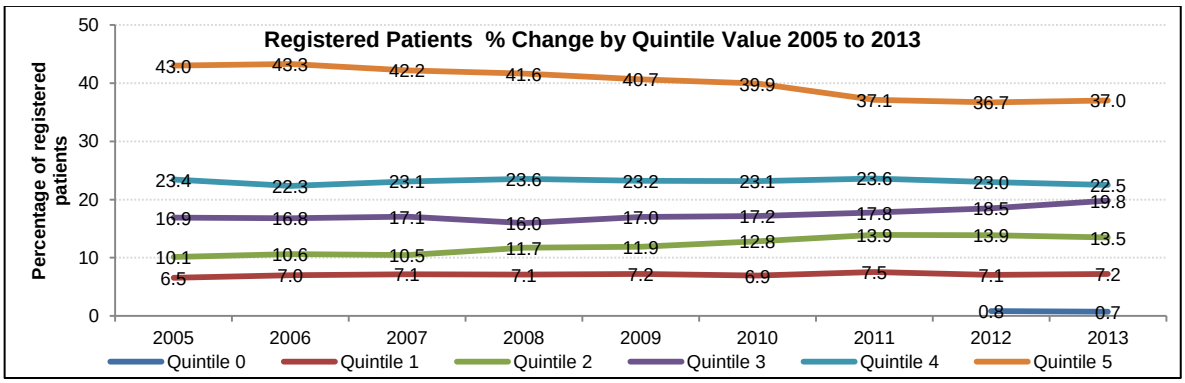


Graph 3



Note: Graph 1-3 excludes casual patients on the NUHS register.

As at 1 October 2013, the distribution of patients by gender at NUHS is 50/50 and as the graph below illustrates there continues to be an increasing trend of patients in quintile 3 in the 2013 year.



Note: Due to Ministry of Health changes in the geocoding system within MedTech, 58 patient's addresses are unable to be geocoded.

Maribeth Major, Operations Coordinator

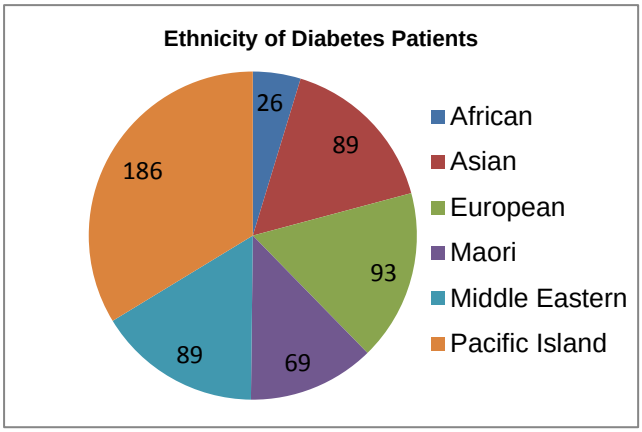
SECTION THREE

The reports in section three give more detailed information about the health care services we provide and the work done with these groups over the period from 1 July 2012 – 30 June 2013.

Diabetes Team Report

The diabetes team comprises of Dr. Tin Maung Maung, Primary Health Care Nurses Fou Etuale and Dianne Theobald and Assyrian interpreter Flora Toma. The team provides oversight of diabetes service and management with the Primary Health Care Nurses providing the majority of diabetes education, assessment and initiation of insulin to patients.

There are 54 newly diagnosed diabetes patients this year, raising our patients with diabetes register to 552 patients in total. Of the total demographic, 125 patients are currently on insulin and 362 patients completed annual reviews in the year.



Collaborative Services

The diabetes team and NUHS are committed to working collaboratively with other service providers to ensure our patients receive accessible and streamlined diabetes care.

- In collaboration with CCDHB diabetes specialist Dr, Jeremy Krebs, NUHS provide a specialist clinic every three months. NUHS patients accessing this clinic have fedback the benefit of having this service within a known and comfortable environment.

- The Taranaki Pacific Island Elderly Group weekly meetings focus on social and cultural aspiration, spiritual well-being and holistic health approaches. In the 2012-2013 year a NUHS Primary Health Care Nurse attended these meetings on a monthly basis to deliver additional health education to the group members. This year's topics included; health screening, medications, health literacy, benefit rights and diabetes information. In addition, NUHS provided a flu vaccine clinic for meeting members in June.

- Retinal screening is carried out predominantly by Clear Vision Optometrist at Newtown, while Patients living outside our geographic area usually visit Barry and Sargent Optometry. Our excellent rate of retinal screening can be attributed to the easy and timely access to appointments at these optometry services.

- We continue to refer to the free diabetes podiatry service, however due to the reduction in hours waiting time have increased from four to six weeks.

- The Well Health Trust community dietician, Louise Beckinsale, has continued to support community and group education and those who need to be seen on one to one basis.

- Supported through NUHS, Te Puna Waiora (previously Te Roopu Manawanui) continues to meet monthly to provide support and activities to members.

Pre-diabetes Advice

The team also focused on pre-diabetes identification to provide education on diet and lifestyle management.

Ia Manuia ma Fa'amanuia mai le Atua.

Fou Etuale
Diabetes Primary Health Nurse - On behalf of the Diabetes team.

Inner City Project (ICP)

In 1998 the Inner City Mental Health Liaison Group in Wellington identified a need to have a more holistic service for mental health service users involving clinical and non-clinical services, and approached the Health Funding Authority (HFA) to fund this service. The ICP was set up as a response to this initiative in 2000. Since then the project has flourished, with the priority being people whose support needs are currently not being met, particularly those who are transient and homeless and have difficulty accessing services.

The Inner City Project (ICP) has evolved into a much established advocacy service within the Wellington and Porirua area. The service provides a coordinated primary health and social service for people with mental health needs. The focus is on linking people into existing services, providing support and advocacy across the mental health sector. In 2007-2013 Inner City Project took on a new team set to make changes for the community of Wellington and the mental health sector. ICP started from a small office in Hall Street to a new community building called Riddiford House.

The ICP team have worked with clients facing immense challenges, in terms of mental health issues, homelessness, poor physical health and social isolation and have provided frontline support to mental health service users, who often have difficulties accessing appropriate services. The team work with clients to make positive changes in their lives and also ensure they have access to services that meet their basic needs, such as housing, safe food sources and engagement with mental health professionals. ICP team provide professional advice, support and advocacy, and represent an accessible, safe point of contact which is crucial to clients on the margins.

The ICP team have been a key player in collaboration between social services and mental health services in Wellington. Cross-sector case management is arguably the best representation of such collaboration working to the advantage of mutual clients. As many of our mutual clients have several issues behind their mental health and homelessness, solutions are required from a number of agencies with expertise in their particular field. Good collaboration between agencies ensures that resources are distributed as fairly as possible and go to those in genuine need – this is the key to faster, more successful outcomes for many of our clients.

Newtown Union Health Service (NUHS) has been contracted by Capital & Coast DHB for more than 10 years to provide Peer Support for Adults and Consumer Advocacy services to support people with mental health needs. This has been the Inner City Project (ICP) contract and although set up as a project, it blossomed and was embedded into the Wellington community and over the last 12 months Porirua.

Through the redesign of the mental health and addiction services in the region, NUHS saw an opportunity to align the ICP contracts with ‘Te Ara Pai Services’. It is with this that as of June 2014, NUHS will no longer manage Inner City Project and this will be immersed into ‘Te Ara Pai Services Stepping Stones to Wellness’. Inner City Project have built relationships with NUHS and the relative clinicians of the service and it is with admiration and respect that Inner City Project have had the opportunity to grow within a aligned provider that’s core kaupapa and philosophy align with that of the community and their needs.

Our team at Inner City Project has been the most efficient and effective team that I have had the privilege to work with and I am very proud of the achievements that we have had as a respectable, collaborative, client focused, compassionate, caring service and hope the future will entail the sense of a strong, robust and professional service where ever that leads.

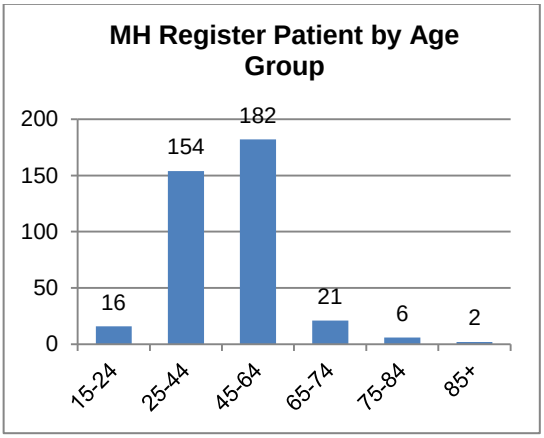
To the team of NUHS it has been an absolute honour and experience to work alongside ground breaking workers that have a heart and soul for their community and Primary Health Care. In ending I would like to thank the team of NUHS, the Board and Fiona Osten Manager NUHS for the support, advice and direction that you have for Inner City Project as a team and service in this sector.

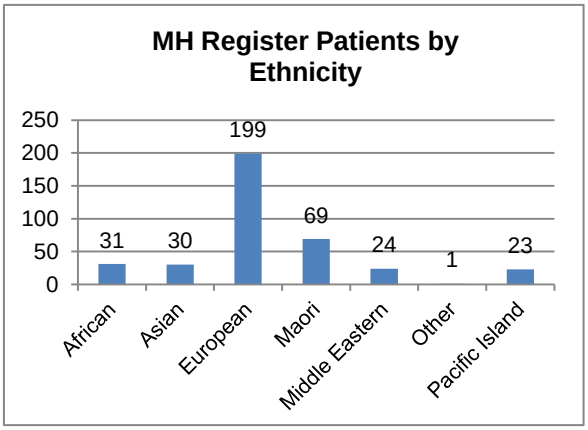
Tina Bennett
Team Leader (ICP)

Mental Health Team Report

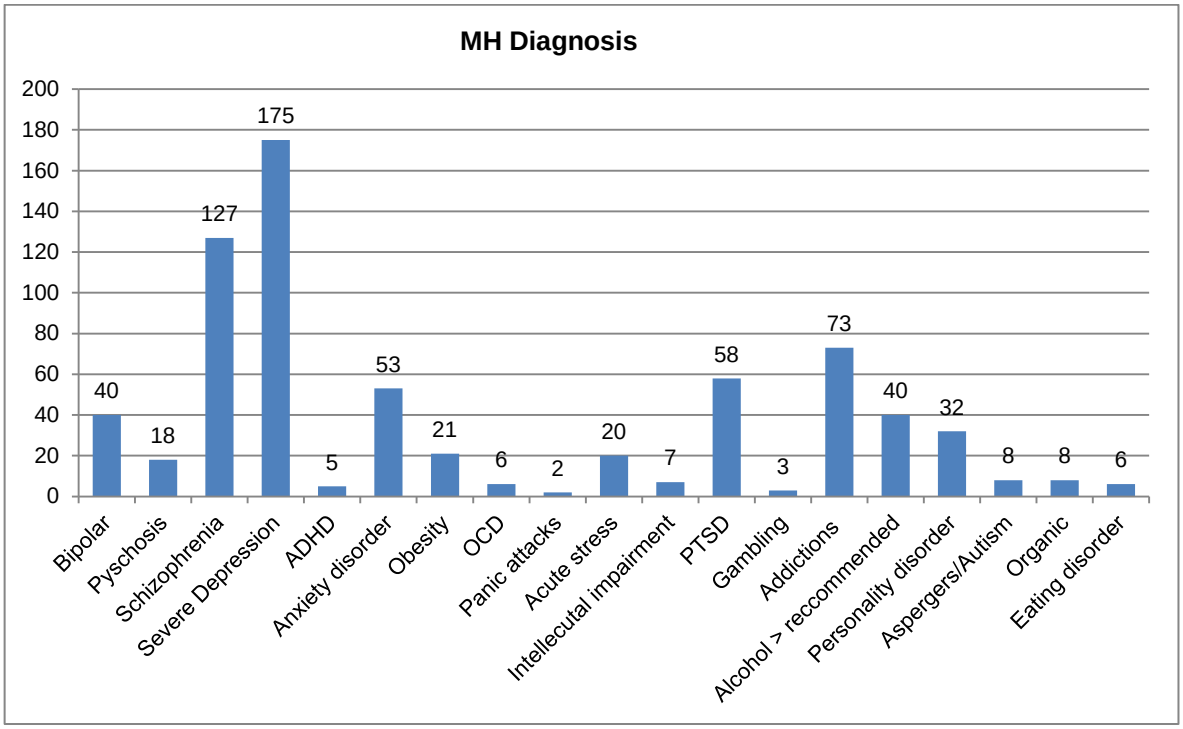
The mental health team comprises of Dr. Pauline Horrill and Primary Health Care Nurses Kieran Monaghan and Asha Clark, who provide oversight of mental health services at NUHS to 332 mental health programme registered patients.

The graphs below define this group of patients by age group, gender and ethnicity. The register is dynamic with a number of exits and new entries according to our criteria of eligibility.





Ongoing dynamic use of the programme to support new clients with high needs effectively is essential for the team. With a large percentage of high deprivation index patients in this programme, the team utilises strong inter-agency coordination and interdisciplinary approaches.



Many of the patients in our MH programme have more than one diagnosis and multiple co-morbidities (on average three long term conditions per patient), which require ongoing management and which posed particular challenges in the 2012-2013 year.

The workload remains high and intensive, with an average of 24 contacts per patient over the year, including booked consultations, on the day services, telephone calls, outreach contacts, home visits, hospital visits, and prescriptions.

Integrated Care Model

NUHS continued to work with psychiatrist Dr Paul French, from the South Community Mental Health Team in the Primary MH Liaison clinic, which enabled swifter access to assessment, medication reviews, and alterations to a treatment plans for patients solely monitored through primary care. This model ensured efficient and effective use of resources, enabling swifter intervention and potentially improved recovery times and reduced referral rates to secondary care for intervention.

60% of the mental health patients in our programme have psychiatric medication prescribed by the General Practitioner. We believe this indicates the strong role our work plays in the integration of care between and within services. Providing clear and accurate communication between services can be very time consuming and is often a hidden time and cost factor in working with these clients.

In addition, the Mental Health team has also been available for clinical support and information to our fellow colleagues and other services, such as Well Health Trust Positive Horizons. Positive Horizons offers short-term intervention and packages of care to the 'mild to moderate' members within our service. Many of these people are not on the MH Register, but may present with equally complex and acute circumstances.

Research

In the 2012-2013 year, the MH Team participated in a School of Otago research project. The MH multi-disciplinary teamwork between NUHS and psychiatrist Dr Paul French was recorded and critically evaluated to assess and analyse the efficacy and efficiency of this way of working. The

findings of the study illustrated a high level of professionalism and close inter-professional team work. Recommendations from the study have been fully considered, notably the need to enhance our ability to record accurately the numerous patients we discuss at these meetings.

Our outreach and community links also remain important to our operations; to be able to be involved and observe people in our community and create positive links to our service.

The Clubhouse, a peer service offering daytime activity and support to people who live and present experiences of mental illness, continues to be a focus for nurse Kieran Monaghan. This outreach clinic has been in place since 2006 and illustrates the benefit of these clinics goes beyond clinical practice; the opportunity to develop relationships and trust are also made in this environment. It is these established relationships that have enabled quality support and advocacy, such as helping to facilitate end-of-life care for several of our community members living with complex physical, social and mental health conditions.

Supported by Well Health Trust and NUHS, The Sendam Rawkustra health/music initiative continues to flourish as an accessible and inclusive health promotion. This initiative takes place at The Clubhouse, Aspire Inc., in Newtown.

The percussion project has mental well-being as a central focus and is primarily for those who have past or current experiences of mental illness. However, rather than focusing on a deficit perspective, the group provides an opportunity for people to develop skill, create opportunities for social inclusion and work towards challenging the stigma which is associated with mental illness.

It has been a productive year to date. The band released a professional recorded CD in May to spectacular enthusiasm. The group located the funds to produce the package by a community crowd funded website, Pozible. Over $3000 was raised via this community activity to enable the band to produce a beautiful and well-received package. The released was marked with sadness though as we dedicated the album to a member, Peter Ferriss, who had died earlier in the year, sadly reminding us again that the heavy weight of emotional distress is always close.

Tim Bell, another long term band member and wordsmith also sadly left us in September. Tim was the author of the Sendam classic Eat and Sleep: The Bipolar Anthem – offering salient words for health and wellbeing and strategies for coping with the difficulties that sometimes present.

The mental health team acknowledge there are a number of on-going significant issues for the patients within the programme, such as increasing cost of living, council housing issues, uncertainty with sector funding, capacity and sustainability of the programme itself and poor health of the aging population (211 of the patients in the mental health programme are aged over 45). Additional demands are made on NUHS to support residential care staff to navigate both the physical and mental health care of patients, while having minimal access to services, such as respite, to help support people in escalating crisis.

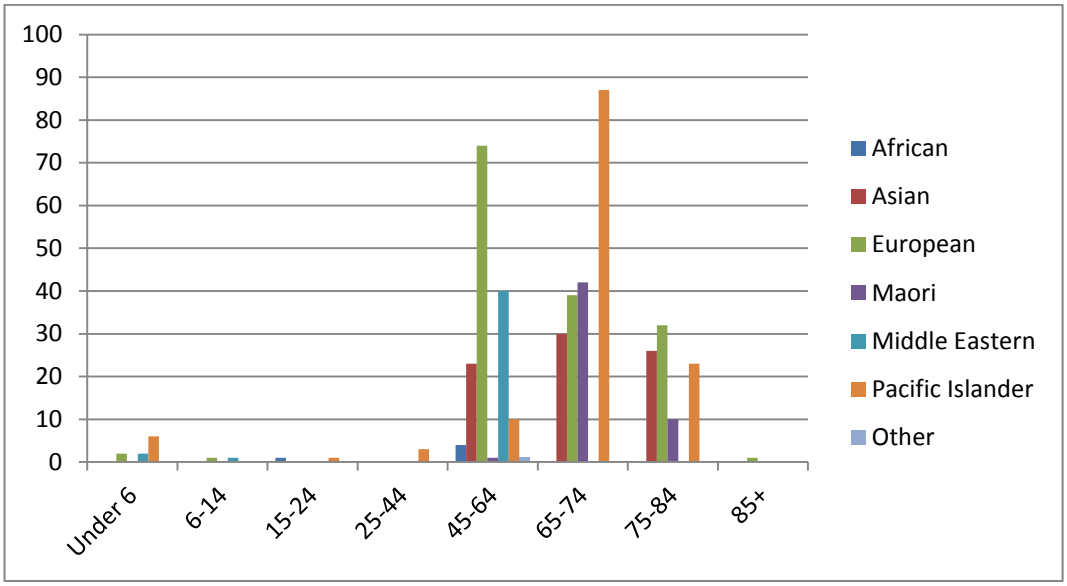
Newtown Mental Health Team

Newtown Park Flats Clinic Team Report

The Newtown Park Flats Clinic team comprises of Dr. Tin Maung Maung and Primary Health Care Nurse Fou Etuale. The purpose of this clinic is to provide and deliver easy access health care (through reducing barriers and inequalities) to tenants. The team has been providing outreach clinic services at the Newtown Park Flats over 25 years.

In the 2012-2013 year, the team has focused on delivering free diabetes health checks, child health checks and immunizations, women's health education and health promotion initiatives. The team also focused referring patients who required further support to specific health or social services.

There were 53 patients regularly accessing services at Newtown Park Flat. A breakdown of the 460 consultations for the 2012-2013 financial year, can be found below.



One of the team's largest on-going challenges is to educate the community to seek help early to reduce unnecessary hospital admissions and control their health and wellbeing. However, through this outreach service, diabetic patients have shown vast improvements in insulin management.

Wellington City Council has shown great support to this outreach clinic and is currently up-grading the clinical services area and supplied equipment for the programme.

Fou Etuale and Tin Maung Maung
Newtown Park Flats Clinic Team

Refugee Team Report

The refugee team comprised of Primary Health Nurses Serena Moran and Mary Tohill, Dr Jonathan Kennedy and social worker Stefanie Döbl. Mary started at Newtown Union Health Service in April 2013 and replaced Serena as the refugee team nurse.

Newtown Union Health Service Refugee Population

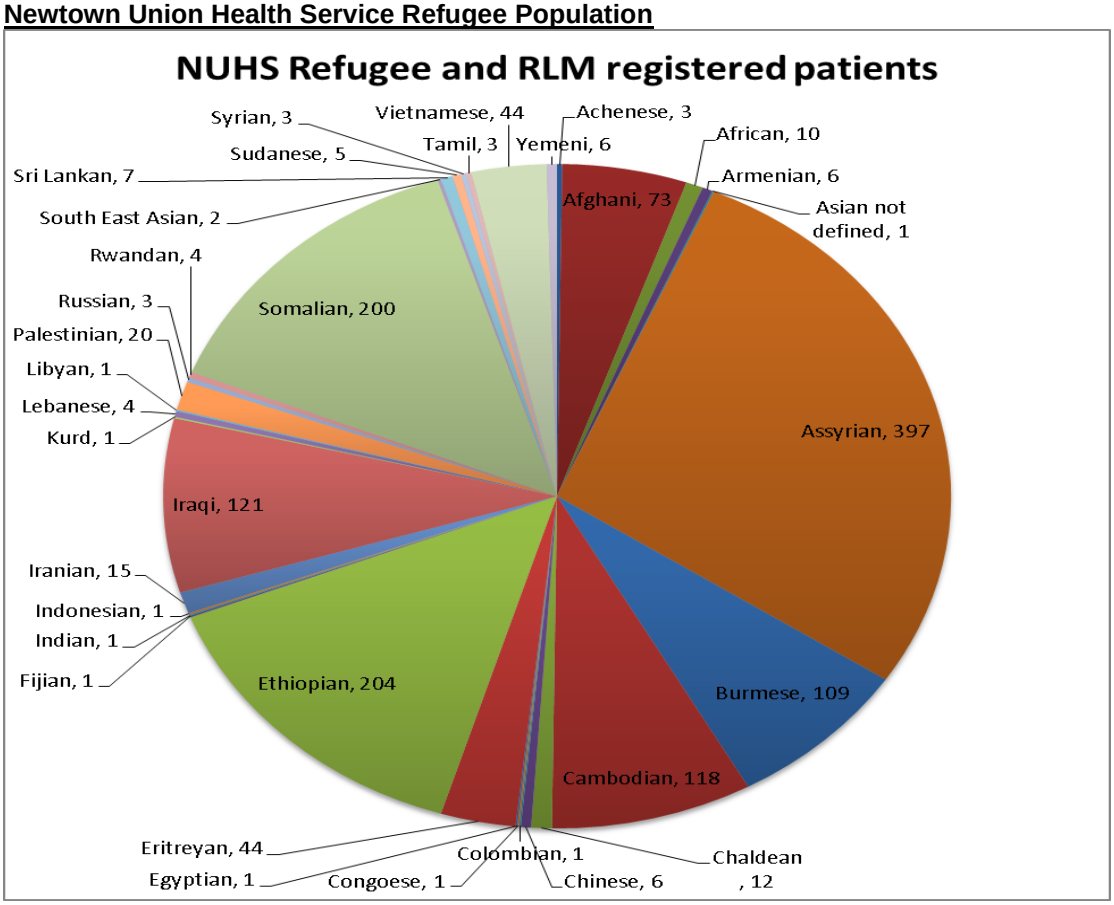


Figure 1: Registered refugee and refugee-like migrant patients at NUHS as at 30 June 2013.

New refugee arrivals in the reporting period

There were 112 refugee and refugee-like migrant arrivals in the 2012-2013 year. This compares with 83 in the previous year. Of the 112 arrivals 74 were quota refugees, 37 were refugee-like migrants and 1 was an asylum seeker. A large number of the quota refugees came from Iraq and Burma.

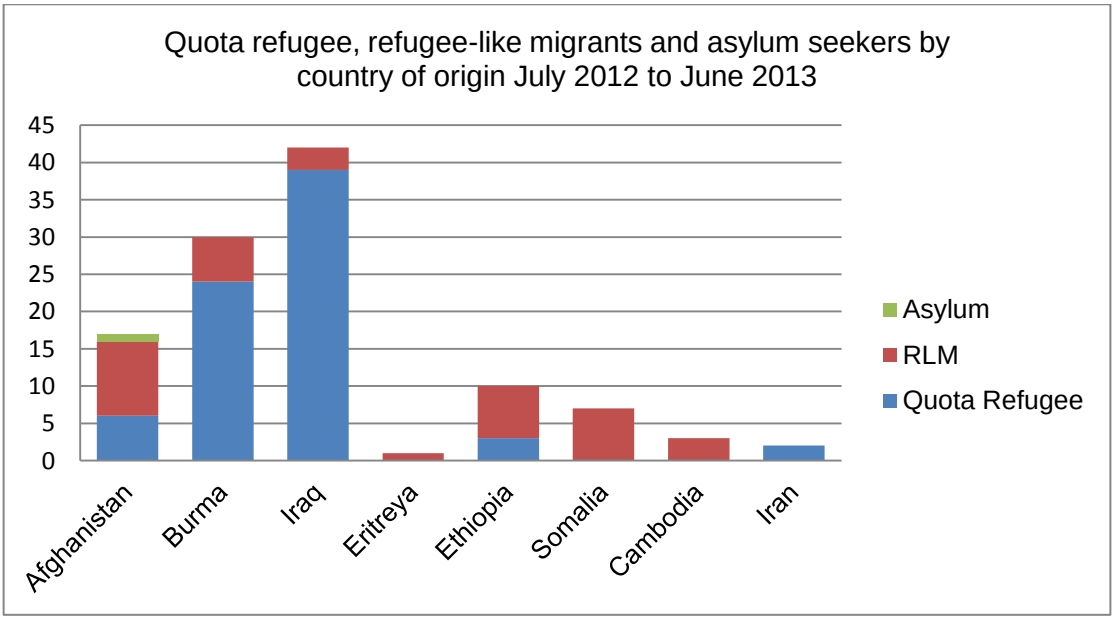


Figure 2: Arrivals by country of origin and refugee type July 2012 to June 2013.

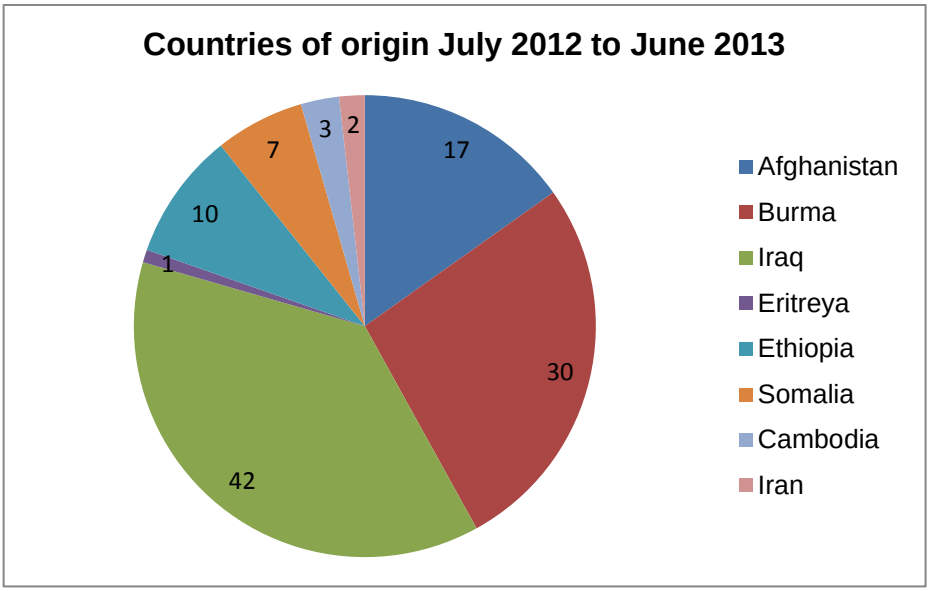


Figure 3: Arrivals by country of origin July 2012 to June 2013.

The team has found people from refugee backgrounds transitioning into life in Wellington are often anxious and bewildered by the environment and foreign New Zealand culture. They are vulnerable to socio-economic hardship and social isolation. Most new arrivals have little or no English language making interpreting services vital when accessing the health system. The NUHS Assyrian interpreter and cultural worker Flora Toma, is greatly valued.

For many refugees the first appointment with a nurse or doctor at NUHS is their first contact with the New Zealand health system. Clinic appointments for refugees are rarely straight forward. Some of the new enrollments in the past months have had severely undertreated conditions such as heart disease and diabetes because in the countries of refuge they come from they have limited access to health services and medicines. Some are elderly requiring a lot of input by the refugee team to address complex health needs.

Many refugees remain well known to the service for years after settlement in Wellington. This is especially true for growing young families and those dealing with chronic health and complex social or psychological conditions. They attend the clinic on a regular basis and have ongoing involvement with the refugee team demonstrating the trust and valuable service the dedicated refugee team provides.

The new arrivals were offered vaccinations to catch up to New Zealand immunisation recommendations, depending on their vaccination history and blood test results. Social work support was available to families either by Stefanie Döbl or by other community social work services.

Feeling home sick is not uncommon amongst refugees regardless of how long they have been in New Zealand. Ties to family and cultural groups gives strength, and shared knowledge gives access to resources. Love and compassion within refugee communities is frequently witnessed by NUHS staff. The worry about physical safety of family and friends left behind remains for some clients. Many refugees are coping with post-traumatic stress disorder or depression. Effective relationships with Refugee Trauma Recovery, Positive Horizons and the Somali Council have been actively maintained to provide coordinated psychological care to clients.

Additional refugee health-related activities by Refugee Team members or by other NUHS clinicians

- 25-26 June 2013 – Serena Moran attended the National Refugee Resettlement Forum organized by Immigration New Zealand. The forum looked at the first stage implementation of the National Refugee Resettlement Strategy. The strategy is promising in that it provides a platform for the delivery of services to quota refugees at a national level and a framework for ensuring quality of service provision. Employment is currently the main area the strategy is concentrating on, with the aim to support refugees into employment early on in their resettlement. Unfortunately the strategy fails to include refugee-like-migrants or

specifically those coming under the 'Refugee Family Support Category', so the current disparity in service provision for this group is set to continue into the near future.

- 7 June 2013 – Serena Moran and Jonathan Kennedy presented at a group of post-graduate students at the Tropical Infectious Diseases Paper at the University of Otago Wellington, on Refugee Health Screening. The NUHS Refugee Team have been invited to present on this same topic at the 'Refugee and Migrant Health' post graduate paper at Otago University, Wellington and the Royal New Zealand College of General Practitioners Annual conference in July.

- 30 May 2013 - Serena Moran attended the Female Genital Mutilation [FGM] Network Action Planning Day which was widely attended by refugee service providers and refugee community representatives. The aim of the day was exploring how an FGM Network could become active in Wellington where there is anecdotal evidence that FGM is occurring especially in some refugee communities.

- A working group was established in early 2013 to look at improving connections between people from refugee backgrounds with disability needs and disability support services, after research conducted by Changemakers Refugee Forum showed significant gaps in this area. Stefanie Döbl attended the first meeting.

- 29 January 2013 – Serena Moran attended a Regional Public Health [RPH] organised forum on working with refugees across agencies in the Wellington area. The forum was an opportunity for service providers to get together and provide feedback to each other on what works and what requires improvement.

- 10 December 2012 – Serena Moran attended the National Refugee Networking Day, Mangere Refugee Resettlement Centre.

Appendix: Refugee-like migrant eligibility criteria:

1. *From a background comparable to people admitted to New Zealand with refugee status* ***AND***
2. *Has similar health needs and requires screening similar to a refugee.*

**NB also referred to as 'direct' refugees, 'humanitarian' refugees, 'family reunification' refugees.*

Specific criteria may include:

- *High rates of endemic disease in country of origin*
- *Poor access to health care*
- *Exposure to trauma*
- *Exposure to war or conflict*
- *Prolonged residence in refugee camps or asylum countries*
- *Forced migration or internally displaced people*
- *Origin from country where refugees are currently originating*

This year the refugee team has been involved with a number of new enrollments of refugee children. The dedication and love of their families is inspiring. It is great to see these children enrolled in school early and adjusting to their new lives.

The refugee team would like to thank Serena Moran for all of her work with the refugee team and Maureen McKillop for her oversight of maternity screening for these women and direction to ensure access of appropriate maternity care for them.

Mary Tohill, Primary Health Care Nurse
Stefanie Döbl, Social Worker
Dr Jonathan Kennedy, General Practitioner

Social Worker Report

Another incredible year has passed by. Hence, I would like to update you about some of the work done during these last few months.

Work with families

Clients and their families continued to experience on-going and often multiple challenges (physical, emotional, mental, spiritual, social and cultural). The main concerns reported referred to housing, financial difficulties, food insecurity, barriers to access adequate and appropriate health/social supports, severe life changes (for example, new health diagnosis, loss of loved ones or family break ups), personal and family members' safety, social isolation and disconnection from the family or community. Systematic barriers especially in regard to dealings with government agencies persisted, impacting thereby on the health and wellbeing of people. In general, the main social work interventions included increasing health knowledge, strengthening coping strategies and ensuring access to information, resources and to informal/formal supports. Advocacy on frontline and higher levels was also crucial. It was great to see that clients stayed resilient and utilised well their strengths in those distressing times, achieving thereby good outcomes for themselves and their families.

Networking

Overall, the relationships and collaborations with community and health providers continued to be strong which led to timely, smooth and appropriate supports for clients. The mutual support between social workers in the wider community remained robust.

Events

Two significant events impacted on the social work service within Newtown Union Health Service. The unfortunate loss of our midwifery team was dearly felt. The focus is now on establishing good relationships with community midwives in order to offer integrated care to expecting clients and their families.

Newtown Union Health Service jointly with St Vincent de Paul received the Capital & Coast District Health Board 2012 'Commitment to Quality Improvement Award' for their collaborative model of delivering social work services to the community. This was a great achievement as it acknowledges the innovative potential of social service and health providers within the wider community.

Finally, I would like to thank clients and their families as well as colleagues at Newtown Union Health Service and in the wider community. Your resilience, passion and commitment remains outstanding and is inspiring.

Stefanie Döbl
Social Worker

Strathmore Community Clinic Team Report

The Strathmore team comprised of Primary Care Nurse Dianne Theobald, Doctor Vivienne Coppell, Receptionist Georgie Makamaka and Co-ordinator Elaine Hill. The team provides medical and nursing care to patients with acute illnesses, as well as monitoring and treating long term problems. The Strathmore outreach clinic has been operating for over 20 years and feedback from the community shows patients find this drop in clinic more convenient that traveling to our Newtown clinic. The clinic ensures NUHS remains committed to its vision of easily accessible healthcare.

Health promotion work runs alongside the medical clinics and include regular breast screening health promotion through Breast Screening Aotearoa, Wellington South Nurses Initiative and ACC.

In addition, a half-day Health Promotion Event was held on the 22 May 2013, which included low impact exercise sessions Hepatitis B screening and information sessions through the Hepatitis B + C Foundation. Additional service providers promoting at this half day event were the Stroke Foundation, Breast Screening Aotearoa, Wellington City Council, Well Health Trust, Plunket and Regional Public Health.

Strathmore Community Health Team

Child Health Team Report

The Maternal and Child Health Team has faced many changes in 2012-2013 year, when the NUHS midwifery service was forced to close due to the funding cuts. Out of adversity grows progress and Primary Care Nurse Maureen fortified a process that ensures that pregnant women accessing NUHS are supported whilst they access a local midwifery services in a timely fashion. The team have continued to follow the women originally supported by the midwifery service through their pregnancies to ensure they are supported and their babies are immunised in a timely fashion.

Immunisations are a growth industry, for the young and old alike. In addition to Diphtheria, Tetanus, Pertussis, Polio, HIB, Hep B and Pneumococcal vaccines at the age of 6 weeks, there are Pertussis boosters for women in late 3rd trimester of pregnancy, post-partum and parents or grandparents who are key care givers/household contacts of newborn infants. Gardasil for teenage girls continues to be an on-going vaccination programme.

Unfunded vaccines, which have been accessed for a number of families, include Meningococcal C, Varicella (chickenpox) Pneumococcal and Influenza vaccinations (which offer greater immunity with high health risks).

Next year it is likely that a rotavirus vaccine will be added to the 6 week, 3 month and 5 month immunisation schedule. A varicella (chickenpox) vaccine is available, but not currently funded. And that's just for the low risk children. There is also a Pneumococcal vaccination that offers immunity to a greater number of pneumococcal organisms for children with high health risks and Influenza vaccine again to those with chronic health needs.

First antenatal visits have been a hallmark of the Maternal and Child Health Teams over the years. This is a crucial time in a woman's life and is important in identifying strengths and risks, related to the pregnancy and after a baby is born. Maureen has been instrumental in developing new referral processes between clinicians when a pregnancy is made known. In addition, pregnancies are followed and our Social Worker, meets with several of these women and families. A group of midwives which utilise an NUHS room twice a week, and have been instrumental in securing some of our women access to midwifery care. We continue to record births in the records of both the mother and child.
Advocacy continues to be a large part of Child Health; advocating for food, health needs, heating, housing, custody and costs.

NUHS has hosted quarterly the Child Development Clinics over the past 5 years. This clinic provides "better, sooner and more convenient" clinical access for children, and next year we hope to conduct a patient/parent survey to see how the clinic has been for them.

The Berhampore Play Group has now been running at Berhampore School for 2 years, Tuesday and Wednesday mornings. NUHS and Well Health with support of Strengthening Families have been key to the establishment and on-going support of the playgroup. We are working with Berhampore School principal to ensure the playgroup continues. We are building a shared vision of a "community hub" to support greater community health and development in our region Wednesdays are the big days, Kai time. Food is prepared, celebrated and shared by and with the children. Island Bay New World has sponsored Kai Time this year.
So this year, the Child Health report is data free and forward focussed -

A quantitative review of this and our Eczema Skin Care Project were presented at the RNZCGP Conference.

Annie Judkins - GP

SECTION FOUR

Financial Report