



NEWTOWN UNION HEALTH SERVICE

# Annual Report 2018 - 2019



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## SECTION ONE

### Newtown Union Health Service Policy Board and Staff

#### Policy Board

<b>Chairperson</b>	Grant Brookes
<b>Treasurer</b>	Julie Lamb
<b>Secretary</b>	Fiona Osten
<b>Kaumatua</b>	Te Urikore (Julius) Waenga
<b>Staff (clinical) Representatives</b>	Dianne Theobald Jonathan Kennedy
<b>Māori Rōpu</b>	Fiona Da Vanzo

<b>Union Representative</b>	Sam Gribben Grant Brookes
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<b>Community Representatives</b>	Julie Lamb Roger Shaw Ibrahim Omer Barbara Lambourn Jacob Paterson Debbie Leyland (Oct 2018)
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#### Staff

<b>Administration Team</b>	Fiona Osten (Manager), Tunisia Pohatu (Reception Team Leader), Sunita Govind (Senior Administrator), Shelley Turner (Executive Assistant), Giordano Rigutto (Finance Administrator), Freya Osten (Clinical Administrator) from May 2019
<b>Allied Health</b>	Philippa Thompson (Social Worker) Belinda Boyce to October 2018, Flora Toma (Interpreter), Jo Moon (PCPA), Sheree Ryder (Student Social Worker placement three months)
<b>GP Team</b>	Vivienne Coppel (Team Leader), Jonathan Kennedy, Tin Maung Maung, Katrina Harper, Ben Gray, Nikki Turner, Phillip Dashfield, Derek Ngieng, Louise Poynton, Angharad Dunn, Lisa Howard, Stancy Kelly and Gabrielle Watts (Registrars), and Howard Livingston (Locums)
<b>Nurse Team</b>	Dianne Theobald (Team Leader), Fou Etuale, Bryony Hales (Locum), Maureen McKillop, Louise French, Sarah Mitchell, Lynn Davies (Locum), Asha Clark, Serena Moran, Rosie Wilson-Burke, Jo Cuncannon, Tiana McKnight, Kate Borman to April 2019, Barbara Bos to January 2019, Cathy O'Callaghan, Marcia Gawith
<b>Reception Team</b>	Debbie McGill, Elaine Hill, Judith McCann, Krys Keenan (temp), Solomon Klinger (Patient Portal Champion), Josie Bain, Freya Osten till May 2019, Vanessa Gray and Ella Checkley from April 2019, Jasmine Bishop from June 2019

## SECTION TWO

### Chairperson's Report



#### **Grant Brookes, Chairperson NUHS Policy Board**

#### ***“Tū tonu mai e te Kaihautū i te kei o tōu waka” – Whakatauākī nā Keri Opai, Te Pou Paeārahi***

“The leader remains standing to guide the canoe even when buffeted by winds”. So says this aphorism gifted to mental health workforce development agency, Te Pou o te Whakaaro Nui, by their strategic lead Keri Opai.

NUHS has been both buffeted by headwinds and pushed along by tailwinds during the 2018/19 year.

Our diverse community was deeply affected by the March 15 atrocity in Christchurch. Many NUHS families have personal links to the Linwood Islamic Centre and Al Noor Mosque. Others are connected to victims through shared experiences of migration, and of the racism and white supremacy in our environment. On behalf of the Policy Board, we acknowledge the trauma inflicted by the terrorist attacks and we stand with our staff and with our community members as they recover.

There have been positive changes in our environment this year, too. The tailwinds for NUHS included changes introduced by the Labour-led government and foreshadowed in my report last year. Increases in capitation funding due to the extension of free primary health consultations to under-14-year olds and subsidies for Community Services Card holders, which came into effect in December, are reflected in our end of year surplus of \$271,934.

The report of the Mental Health and Addictions Inquiry, to which NUHS contributed, was also released in December. It has recommended transformation of primary health care, seeing it as a critical to addressing mental health and addiction needs.

The allocation of \$455m in Budget 2019 to provide access to primary mental health care for 325,000 people by 2023/4 is likely to boost the services provided or located at NUHS – including for those traumatised by the Christchurch attacks. We were greatly honoured that Prime Minister Jacinda Ardern, Health Minister David Clark and other government MPs chose to make this Budget announcement at NUHS.

Meanwhile the Health and Disability Services Review, which got under way this year and is due to conclude in 2020, heralds large-scale disruption for primary health care in New Zealand. It's not yet clear to what extent it will be a tailwind for us, or a headwind. A submission to this review was made on behalf of NUHS by our national advocacy body, Health Care Aotearoa.

Closer to home, the major challenge for the Policy Board this year has been the increasingly urgent need to address the state of our building at 14 Hall Avenue. Built in 2000 as a temporary structure on land owned by the Methodist Church, the main base for our service is approaching

the end of its expected life and is starting to show significant wear and tear. In August, a quote for \$546,882.21 was obtained for remediation work which would extend its lifespan by a further 20-25 years.

The Board considered a range of options over the course of the year, including relocating, rebuilding and seeking to purchase the land on which it is situated. Following a meeting with the builder and the remedial architect in May, we settled on a preferred plan to undertake extensive remediation to the existing building, subject to the necessary consents being obtained and a satisfactory renewal of the lease for the site. Due to begin next year, the cost for this work will be higher than the quoted amount due to inflation and updated project specifications.

In stakeholder relationships, the big development of 2018/19 has been the new partnership with Whitireia tertiary institute. We have signed an agreement to work together to develop online primary health care nursing training modules. On completion of this work the modules will be the intellectual property of Whitireia with NUHS having access for free. The modules will be available to other organisations or institutions to purchase and the fee will be divided equally between Whitireia and NUHS.

Partnerships with other tertiary education providers remain healthy. A research proposal from Otago University was accepted, after a review of the NUHS Research Policy.

Operational highlights for the Policy Board have included ongoing improvements as part of the NUHS Health Care Home programme, which is now completing its third year. These included roll-out of the HCH concepts at the Massey University site. The Policy Board was also pleased to support the creation of a Nurse Practitioner role at NUHS.

At the governance level, work on updating the NUHS Constitution – which began back in 2014 – has continued. Although we expected it to be concluded before the end of the 2018/19 financial year, approval of the new Constitution will be sought at the 2019 AGM in November. Ongoing appreciation is due to Barbara Lambourn and Fiona Osten for leading this work. Governance attention now turns to reviewing and updating the NUHS Strategic Plan and to professional development for Policy Board members, both scheduled for early in the 2019/20 year.

The composition of the Policy Board meanwhile has remained stable in 2018/19, with gradual evolutions rather than wholesale changes in our line-up. At the 2018 NUHS AGM, the Policy Board bid farewell to long-serving community representative Debbie Leyland. Debbie had spent five years on the Policy Board – the last three as Deputy Chairperson. During this time Debbie championed the needs of mental health service users and those on low incomes, and provided a direct connection to wider health advocacy groups through her role as coordinator of UCAN – United Community Action Network.

The vacancy was filled by the election of Roger Shaw, who returns to the Policy Board after an eight year break. A decision to expand the size of the Policy Board also allowed us to second a community representative from our new Massey University Student Health Service, welcoming Jacob Paterson.

I acknowledge too the remaining Board members who have guided the NUHS waka as it was buffeted by winds this year – Staff Reps Dianne Theobald and Jonathan Kennedy, Tāngata Whenua Rep Fiona Da Vanzo, Community Rep Julie Lamb and Manager Fiona Osten. I am also grateful to Board Minute Taker Shelley Turner and Finance Leader Giordano Rigutto, without whose support I could never have fulfilled my role as Chairperson.

Nō reira, ā tērā tau kia hora te marino, kia whapapapa pounamu te moana, kia tere tonu tō tātou waka.

Next year may peace be widespread, may the calm sea glisten like greenstone and may our canoe speed onwards.

## Manager's Report



 **Fiona Osten, Manager**

Over this last 12-month period NUHS has continued to meet the demands of the challenging and busy health environment. This report covers some of the activities undertaken to meet the demand.

This year the team have continued the focus maintaining the Royal College of General Practice Cornerstone Accreditation. The work required to achieve this accreditation is no small task. This has been led by Dr Vivienne Coppell who has worked long hours coordinating and collating the information needed. Thank you, Vivienne.

We have entered Year 3 of the Health Care Home. I am pleased to say we have continued to achieve the targets set and have received the additional risk funding associated with achieving the targets.

We have been in discussions with the Trinity Church and The Board of Administration of the Methodist Church of New Zealand to renew the lease for the use of the airspace above the carpark. The renewal of lease allows NUHS Newtown Clinic to remain where we are for a further 21 years as a minimum. The remedial work required to prolong the life of the building is a significant investment and now we are assured of remaining here, then the work on the building will continue.

NUHS has now been providing the medical services at the Massey Student Health and Counselling Centre for 14 months. This is a new area of work for NUHS and the last year has been busy aligning how we work at the new site, reviewing processes and generally making sure that the service operates effectively. The recruitment of the additional staff needed has been time intensive and on-going. The NUHS team working at Massey has worked with the flexibility needed when building a new service and what has been achieved is a credit to this team.

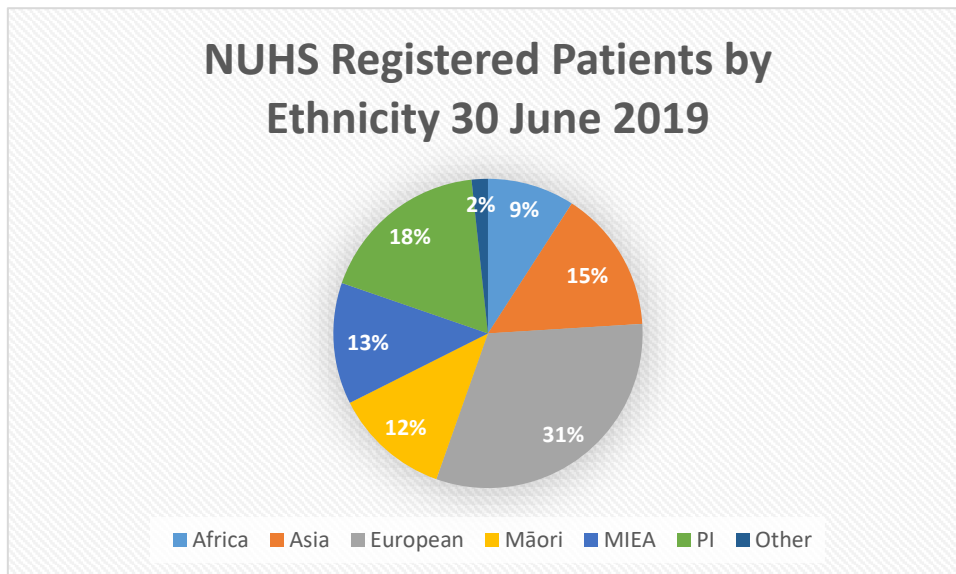
In February Nurse Team Leader Dianne Theobald and I were very pleased to attend the graduation of Jo Moon, who completed her Primary Care Health Care Assistant training. This is a new role to NUHS and Jo is now working across the 3 NUHS clinic sites providing and supporting health services for patients.

Every successful organisation is reliant on having a team of committed staff and I can report NUHS has a team of highly skilled and resilient people. The team work incredibly hard and I would like to sincerely thank them for their dedication to the service and the people to whom we provide care.

A sincere thank you to our Kaumatua Te Urikore (Julius) Waenga for his commitment and support for the service. I would like to thank Grant Brookes, Chairperson and the Board for their leadership and guardianship of NUHS.

## Patient Register and Demographics Report

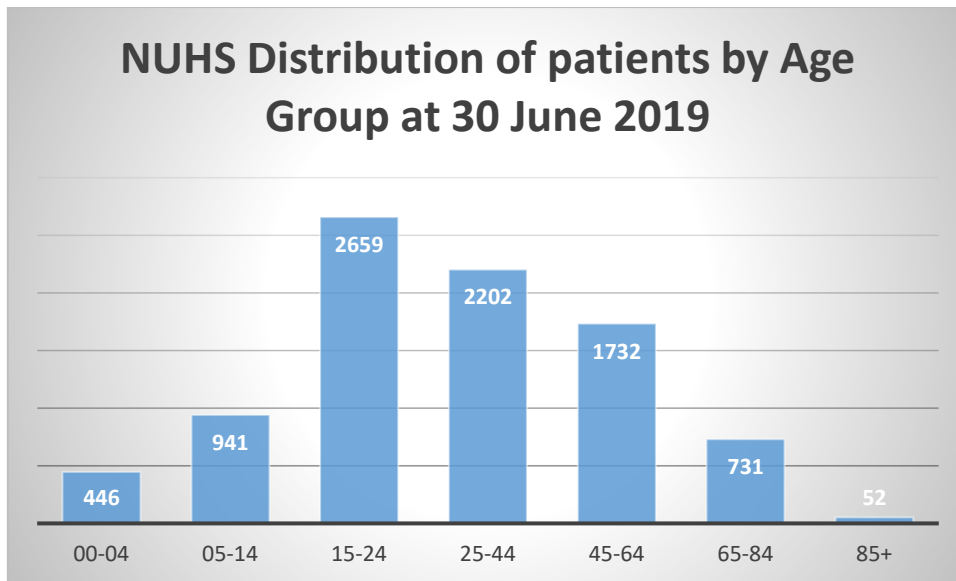
At 30 June 2019 the number of NUHS funded patients was 8,763. This was an increase of 299 on the previous year and can be attributed in part to the Massey students who, on completion of their studies, chose to stay registered at NUHS. This number does not include casual patients who may still be in the process of being enrolled, transferring out or not eligible for NZ Government funding. Patient complexity continues to increase which means register size still does not capture the amount of work involved in providing services to patients.



Source:  
Newtown  
Union  
Health  
Service,  
MedTech

The pie graph above shows the breakdown of registered patients by ethnicity. This interesting demographic reflects the diversity of the NUHS patient population and shows European as a smaller percentage than what can be seen in most non-high-needs populations. The European component is 31% which is higher than past years and reflects the merge of the Massey University Student Health Service with NUHS where there is a higher number of European students registered. This year the next highest group is Asian at 15% then Pacific Peoples at 18%, Middle Eastern at 13%, Māori at 12% and African at 9%. English is the second language for 67% of the registered population which brings a complexity of its own when providing health services.

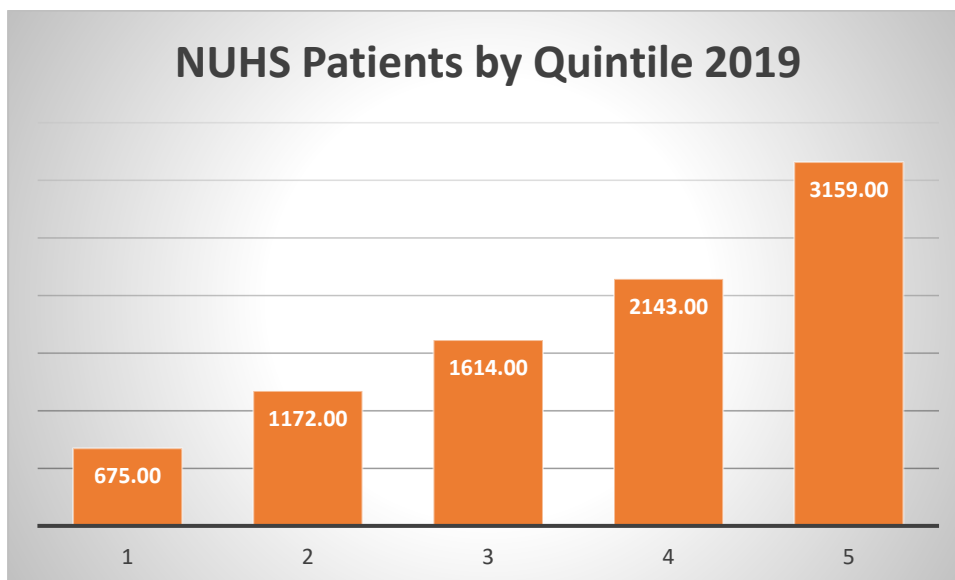




Source: Newtown Union Health Service,

The distribution of the population by age group is shown in the graph above. Since the merge with Massey this too has changed the NUHS demographic.

This year the majority of the registered patients are aged between 15-24 years of age with the second group the 25 to 44 years old. In previous years we reported that the majority of patients were in the 25 to 44 year age group followed by the 45-64 age group. The change in demographic brings opportunities to make sure that service provision is provided in a way that is relevant to all age groups across the Newtown, Broadway and Massey demographic.



Source: Newtown Union Health Service MedTech

The graph above shows the breakdown of the population using the NZ Deprivation Index (NZDep). Quintile 1 represents people living in areas of less deprivation and Quintile 5 those living in areas of greater hardship. The majority of NUHS registered patients are represented in Quintiles 4 and 5.



This tells us that there are a significant number of NUHS registered patients who are susceptible to living with poorer health and have limited access to the resources that keep them well. This is not the full story. As the Southern and Eastern suburbs have become gentrified over the last 30 years there are people who still require greater support to access health care but it is not easy to have adequate funding to provide the high level of care that they need. This is not a new issue and we are hoping that future changes to funding will address some of these issues.

### SECTION THREE

The reports in this section give more detailed information about the health care services provided and the work done with these groups.

#### Diabetes Report

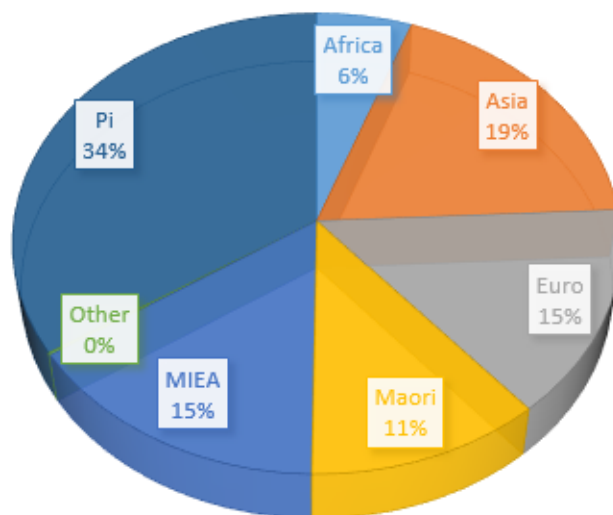


#### *The Diabetes Team*

Newtown Union Health Service (NUHS) provides a comprehensive Diabetes screening, assessment and treatment service to an approved Diabetes Management Plan (DMP). We have a team of health professionals and allied health workers who provide the oversight of diabetes services at NUHS. The team members are Dr Tin Maung Maung, Dr Derek Ngieng, Nurses Dianne Theobald and Fou Etuale, Clinical Pharmacist Linda Bryant, and Interpreter Flora Toma.

There are 611 registered patients who have a diagnosis of diabetes, 611 with pre-diabetes, and 43 with gestational diabetes. Of these groups 578 have Type 2 diabetes and 33 have Type 1 diabetes.

**NEWTOWN UNION HEALTH SERVICE  
PERCENTAGE OF PATIENTS WITH DIABETES BY ETHNICITY**



NUHS has a Diabetes Education Programme that covers all aspects of diabetes care, including initial assessment and education and ongoing screening with recalls for follow up.

The programme is delivered on an individual basis at regular scheduled appointments with the patient's allocated nurse. Regular appointments provide the opportunity to monitor and manage the patient's condition and set future goals. All clinicians work with their patients to set and review goals with the aim of reducing the long-term negative impact of diabetes as well as improving overall wellbeing.

We currently offer funded diabetes appointments to see a nurse and a funded annual review with either their GP or nurse. Patients starting on insulin are supported by funded appointments to establish their insulin regime and ensure that they are able to manage their treatment in a safe way. The Clinical Pharmacist also offers appointments to review Diabetes medications and is available to initiate insulin if required.

We regularly screen patients who may be at risk of developing diabetes and provide diet and lifestyle education to people who have been identified as having pre-diabetes. These groups are monitored regularly to ensure early detection of any progression of their condition.

Outreach nursing services are available to people with Diabetes where we have identified barriers to them attending appointments. The Pacific Navigation Service provides support for Pacific patients to access NUHS.

A NUHS Diabetes Nurse Educator coordinate's a monthly health promotion for the Taranaki Exercise Group. Pacific patients are encouraged to attend this group for regular exercise and health promotion.

Māori patients with diabetes are referred to and encouraged to attend Te Puna Waiora which is a group providing education and support for people living with diabetes and other long-term conditions.

Regular activities of the Diabetes team include:

- Three monthly Diabetes Specialist consultation clinic with Dr Jeremy Krebs for patients with HbA1c >64 and higher level of complexity. 13 patients were seen and 33 cases were discussed during this period.
- Regular education to update staff on best practice management for people with diabetes.
- Interdisciplinary consultations involving nurses, dietitian and clinical pharmacist.
- One on one mentoring of nurses by staff Diabetes Nurse Educators.
- Monthly group health education and support by Diabetes Nurse Educator to community Pacifica Group (Taranaki Group).
- Regular outreach nursing service for Pacific People as well as people with high needs where there are identified barriers to them attending appointments.
- Fortnightly dietitian clinics run by Emma Jones, Community Dietitian at both Broadway and Newtown sites.
- Regular contact with community Podiatrists to ensure collaborative approach to managing patients with Diabetes.
- Liaison with local Optometrists to ensure people have access to retinal screening services.
- Two nurses are members of the Diabetes Nurse Practice Partnership Team which is a collaboration between primary and secondary care and works to promote quality and consistency of diabetes services across the region.
- One nurse is an active member of the Wellington Regional Diabetes Clinical Network which has oversight of Diabetes Services in the greater Wellington region.

There is an ever-increasing number of people being diagnosed with pre-diabetes and Diabetes. This includes increasing numbers from younger age groups diagnosed with Type 2 Diabetes. This is in part due to the increasing incidence of obesity and more sedentary lifestyles and will have wider ramifications as this group will more likely suffer from the long-term complications of Diabetes.

## Mental Health Report



### **The Mental Health Team**

The Newtown Union Health Service (NUHS) Mental Health Team currently consists of Dr Louise Poynton. Nurse Rosie Wilson-Burke has been a valued member of the team who has now moved on to different areas within the service.

NUHS currently has 375 patients enrolled on the mental health programme. This is 5-6% of the NUHS population, excluding the Massey Student Health population as this group is not included in the mental health contract.

#### **Liaison clinics:**

- Bi-monthly 30min meeting with Opioid Treatment Service Primary Care Liaison
- Fortnightly 60min meeting with Dr Paul French, followed by a 2 hour clinic for patient reviews by Dr French
- 3 monthly meetings with TACT, WCMHT, Te Whare Marie and Health Pasifika are currently in the process of being confirmed

#### **Other activities:**

- The MH team hosted an education session for all staff delivered by the Opioid Treatment Service regarding structure and role of the DHB Addiction Service
- Presentation to the practice regarding the MH contract and access to MH services
- Education session to staff on de-escalation techniques
- Education sessions with nursing staff regarding use of AIMS (abnormal involuntary movement scale)

#### **Outreach:**

- 3monthly GP clinic at a supported living facility, run by Emerge Aotearoa, with liaison and support provided as needed between scheduled outreach clinics

#### **MH Programme**

It is difficult to be clear on long term trends regarding number of enrolments on the MH register due to changes in how data has been collected over time. However it would appear there is a slow trend to increasing numbers of patients registered, and an expected increase in utilisation rates for existing patients due to long term severe mental illness with coexisting physical comorbidities and an ageing population. The MH team attempts to liaise with community MH teams to facilitate physical care of patients who are registered with both a community team and NUHS.

NUHS provided a written submission to the Mental Health and Addictions Enquiry and was proud to host Prime Minister Jacinda Ardern, the Minister of Health David Clark and their team at the announcement of the Government's response to this enquiry on Wednesday 29 May 2019.

The priorities for the MH team moving forward are continuing to update our processes and to improve rates of metabolic monitoring for NUHS patients, in order to try and optimise physical health and promote better health outcomes for patients with serious mental illness. This involves updating and improving the way we document and identify health information at the time patients are enrolled on the programme, and working back through the current enrolments and updating recalls.

NUHS is working proactively to monitor side-effects of MH treatments and as part of this we are implementing the regular use of AIMS monitoring, which is a way to identify serious side effects of antipsychotic treatment. This will become increasingly important as our population on long term MH ages, as many of these side effects are cumulative over time.

There are a number of initiatives currently underway in the community regarding increasing access to mental health care that are relevant to the NUHS patient population. The Piki project provides access to counselling either via self-referral or via a health professional for patients aged 18-25. There has recently been a new online programme "*Just a Thought*" released to provide free online CBT based modules for depression and anxiety.

## Clinical Advisory Pharmacist Report



***Dr Linda Bryant, Clinical Advisory Pharmacist***

The Clinical Advisory Pharmacist (CAP) works 2.5 days at NUHS, 1.5 days funded by Tū Ora Compass and 1.0 days funded by NUHS. The service is provided primarily from the Newtown Clinic, with half a day at Broadway clinic.

Pharmacist facilitation has continued to be a combination of clinics for patient appointments to optimise medicines, repeat prescribing to identify potential medicines issues, opportunistic patient consultations and medicines information/ recommendations. Medicines reconciliation is a growing workload. The continual focus is optimising medicine therapy, though as further integration in the practices continues and a blurring of boundaries occurs, as expected for the health care home, lean thinking and obtaining maximal optimisation of skills is essential. Contact with patients may be in clinic, telephone or Manage-My-Health. There is increasing use of Manage-My-Health for communication and patient's booking themselves into my clinic times.

The general focus for medicines optimisation is long term conditions such as diabetes, cardiovascular disease, gout and respiratory conditions. Other specific project areas include the on-going focus on the treatment of hepatitis C, plus the discontinuation of doxepin and dothiepin which has required prescribing plans to be developed for switching to an alternative medicine.

Medicines information enquiries are constant, often requiring an immediate answer as a clinical decision is required. Being readily accessible is important for these enquiries.

The CAP has also attended and presented at the general practitioner peer group, discussing asthma therapy and the potential place of cannabis-based medicines.

## Outreach Immunisation Report



### *The Outreach Immunisation Team*

Newtown Union Health provides Outreach Immunisation Services on behalf of Tu Ora Compass Health, for Capital and Coast DHB. The contract area is from Churton Park south and referrals are received from any services providing care for children. Self-referrals are accepted.

The team consists of 2 experienced registered nurses working part-time, and an administration support person.

For this reporting period the service received a total of 349 referrals.

119 children were given vaccinations during the reporting year.

15 referred children had left NZ, and 34 referrals were unable to be contacted, and 29 referrals declined the OIS service.

Most of the immunisations were given in the child's home, some in a clinic setting, immunisations were also given at a Kohanga Reo and a local school.

A number of different communication methods are used to follow-up referrals. This is through telephone calls, text messages and home visits made by the Outreach nurses. This reflects the diverse and flexible model required to action referrals. Multiple attempts are made to contact families, reflecting the significant effort and challenges the nurses' face in reaching high needs and vulnerable families.

During this past year, 722 telephone calls were made, 240 texts sent, and 281 home visits were made by the nurses.

The Outreach Immunisation team continue to work collaboratively with local Plunket nurses, Primary Care Nurses and the National Immunisation Register team to contact and reach families that have difficulty in engaging with their primary care provider.

The team liaises with a wide network of health professionals, and referrals were made to Ora Toa OIS, local Tamariki Ora and Plunket nurses, and GPs for further health care.

The Outreach Nurses attend regular meetings with the wider immunisation stakeholder's network. Both nurses have attended professional development courses in the areas of child health and immunisation, and attended the NZ Immunisation Conference and workshop in September in Auckland. This provided the team an opportunity to enhance their knowledge and skills as well a chance to network with other immunisation providers.

The OIS service provides a valuable contribution to improving and achieving immunisation targets. Many families have limited resources, which creates barriers to their access to primary health care. No telephone contact, frequent changes to where the families are living, and limited transport options contribute to barriers to accessing care. The OIS team works alongside families to reconnect them to their primary health providers. A positive interaction with the OIS team in their own homes contributes to this re-engagement.

## Newtown Park Flats Clinic and Outreach Report



### *Fou Etuale and Tin Maung Maung*

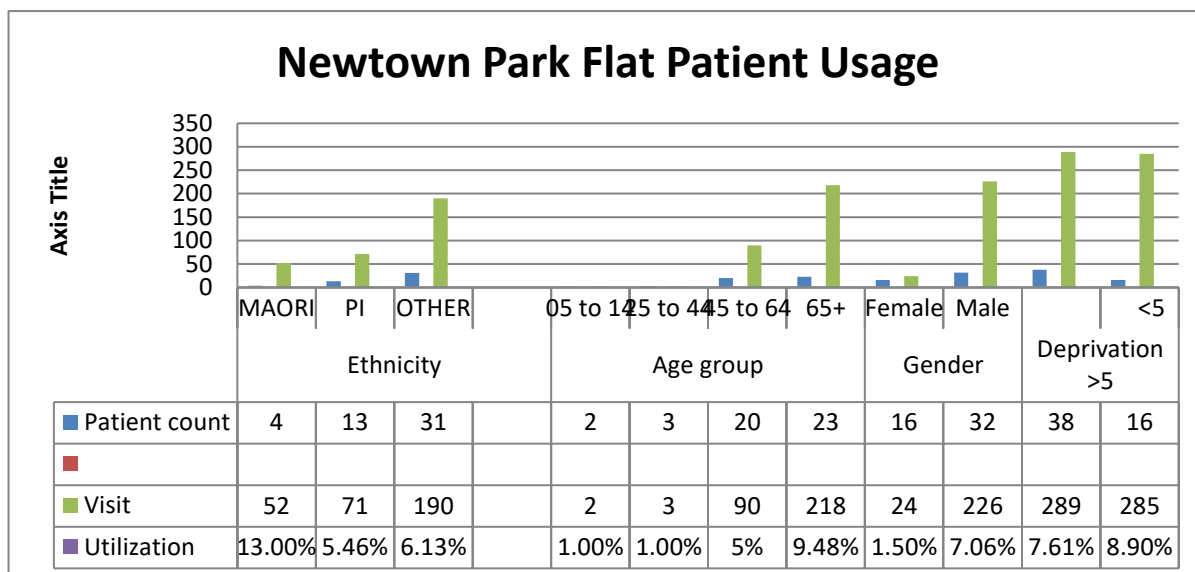
Newtown Park Flats (NPF) outreach clinic operates weekly on Fridays by a nurse; doctor attends on first Fridays monthly. The clinic is situated at D Block on the ground floor at 320 Mansfield Street Newtown.

The purpose of the clinic is to provide accessible and low cost health care to those living with a low income and reside at the flats and surrounding areas. Our aim is reducing barriers and health inequalities.

The clinic delivers full medical care including health checks on asthma, diabetes, sexual health, mental health, blood pressure checks, child health checks, immunization, social support, smoking cessation, elderly support, health education, health promotion etc. Those who need urgent support or treatment are referred to Newtown Union Health Service clinics'. Patients needing social support are assessed and referred to the NUHS social worker or appropriate social service providers.

#### Newtown Park Flat Registered Population – June 2019

Ethnicity	00 to 04	05 to 14	15 to 24	25 to 44	45 to 64	65 to 74	75 +	Total
AFRI	12	11	2	23	6			54
ASIA	1	2	3	3	5	6	1	21
EURO	3		3	6	7	1	3	23
MAORI			2	4	6	2		14
MIEA	2	3	1	14	4	4	2	30
OTH	1				3			4
PI	5	5	3	4	12	1	4	34
Total	24	21	14	54	43	14	10	180



The current registered population stands at 180, an increase from 179. Forty eight patients were consulted 313 times during the last 12 months. Middle Eastern were the highest users followed by Pacific Islands, European, Maori and Asian. 47.92% of the service consumers are 65 years and above age group. Majority of the clinic attendees were male (32= 66.67%). Thirty eight out of 48 clients attended at NPF clinic were at deprivation index of 5 (79.17%).

Home visits are also a key component of this clinic to provide health care to house bound clients. We had made 23 home visits during this period. Fourteen clinic sessions were closed during this period due to public holiday, staff shortage and staff sickness. We have had two flu immunization clinics at NPF during this period.

## Refugee Report

### **The Refugee Team**

The Refugee Team over this reporting period has consisted of Belinda Boyce (Social Worker), Philippa Thompson (Social Worker), Barbara Bos (Primary Health Care Nurse), Cathy O’Callaghan (Primary Health Care Nurse), and Jonathan Kennedy (General Practitioner). Belinda Boyce and Barbara Bos left during the reporting period and Philippa Thompson has returned from extended leave. The team is supported by Serena Moran (NUHS Primary Healthcare Nurse).

Jonathan Kennedy, Cathy O’Callaghan, Serena Moran and Philippa Thompson attended community events, including a vigil at the Wellington mosque for the first Friday prayers after the attack, and the mosque open day that was held a few weeks later. Our thoughts remain with those who will continue to be affected for a long time to come.

Other activities included:

- *Refugee Liaison Meetings* held monthly with Red Cross resettlement support social workers, Red Cross Refugee Trauma Recovery mental health professionals, Regional



Public Health public health nurses, and other health professionals working in the refugee sector.

- Philippa Thompson attended the 6-monthly service provider meeting led by Immigration New Zealand and Ministry of Business Innovation and Employment.
- Barbara Bos met with Caroline Boyle from Regional Public Health in September to clarify work being done by both RPH and NUHS with the aim of streamlining our processes.
- Barbara Bos attended the National Refugee Nurses Networking day in Christchurch in December 2018 which was valuable for gaining insight into issues occurring in other regions. Networking with the other nurses including from MRRS was good for clarifying and resolving issues.
- In August – September 2018, Jonathan Kennedy agreed to advise Immigration New Zealand, with a primary health care perspective, for their review of the health services provided to quota refugees in New Zealand.
- In August 2018, Serena Moran and Jonathan Kennedy presented their research regarding refugee-like migrant and quota arrivals to Newtown Union Health Service to the Newtown Union Health Service staff.
- In March 2019 Cathy O’Callaghan attended the Red Cross Orientation day for the new intake of refugees. There were presentations from Regional Public Health, Refugee Trauma Recovery & the Bee Healthy Dental Service.
- Cathy O’Callaghan & Philippa Thompson attended the Former Refugee Stakeholders meeting in May which focused on responses to the Christchurch shooting, with special regard to Wellington-based refugees.
- World Refugee day in June was acknowledged & celebrated with a shared staff lunch at NUHS featuring global cuisine. Cathy O’Callaghan also attended the opening night at the City Gallery in Wellington of a Black & White photography exhibition supported by ChangeMakers Refugee Resettlement Forum, showing Wellingtonian former refugees, by Ehsan Hazaveh, himself a former refugee.
- Jonathan Kennedy was appointed to the MBIE Refugee Quota Project health screening review steering group, giving a primary care perspective to proposals designed to cope with the government-announced increase in quota refugees from 1000 to 1500 in 2020.
- Serena Moran presented in May 2019 to post graduate students undertaking the ‘Tropical Infectious Disease’ paper at University of Otago Wellington, on refugee health screening in primary care.
- Jonathan Kennedy and Philippa Thompson were interviewed In April 2019 by Micaela Rae – Masters Student, Australian National University, regarding refugee health service provision in New Zealand, participating in her research.

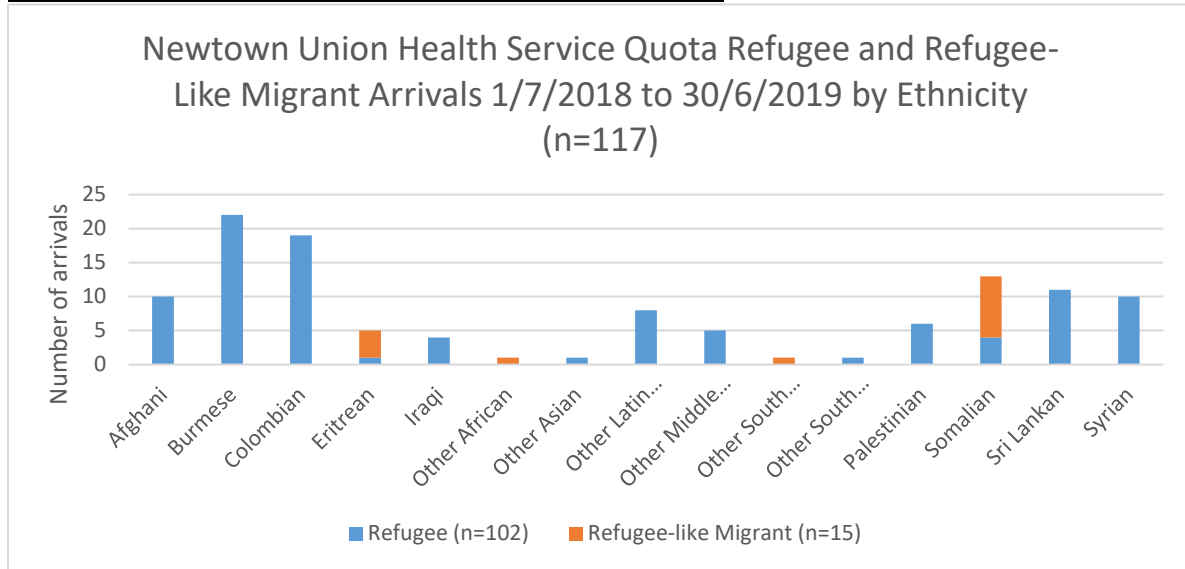
- Jonathan Kennedy was interviewed in February 2019 by Sumera Akhtar, PhD student, University of Otago, participating in her research relating to services provided to refugee arrivals.
- The team noted that housing remains an ongoing issue for many of the former refugees. Based on information provided to us by Red Cross, we expect that, due to difficulty sourcing appropriate housing, intakes of quota refugees to change in 2019 to smaller intakes but with more intakes per year.

### **Social work with refugees**

The social work role with refugees usually starts after Red Cross close, one year post-arrival. However, due to the housing crisis, many new arrivals are now being placed in private rentals, which at times have turned out to be unsuitable. Therefore the social worker has at times co-worked with Red Cross social workers to advocate for other housing options.

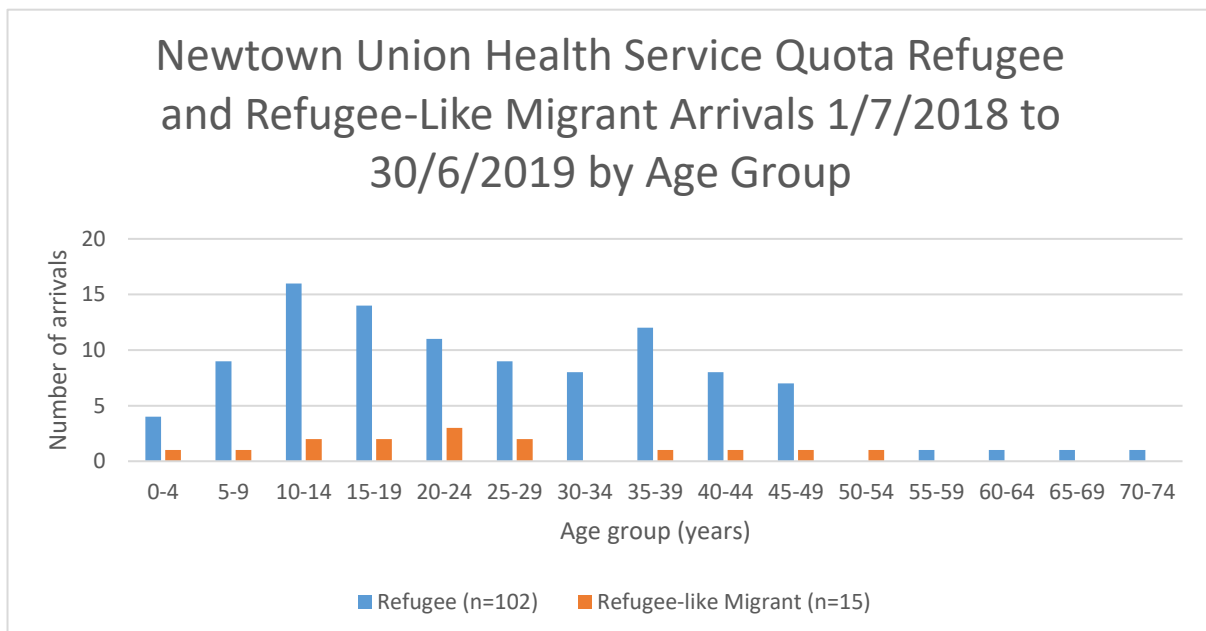
The housing crisis also affects refugees who have been in New Zealand longer, as changing family dynamics (babies born, new partners, children leaving home) change the housing need; houses may also be unhealthy due to damp and cold or safety concerns. Housing need is by far the most common reason for social work referral for refugee and non-refugee clients alike but particularly affects refugees who do not have a knowledge of New Zealand services or networks of family support. Even in urgent cases there is frequently a long wait for appropriate housing. This is a frustrating time for families. The social worker assists families to apply for social housing and Wellington City Council housing, advocates to ensure social housing applications are appropriately prioritised on the register and then supports the family to manage expectations during the waiting period. When families do not have a house that meets their needs and where they feel at home, it severely negatively impacts on their ability to settle in New Zealand. It is difficult to focus on English classes or engage with mental health services or support children at school, when all focus is on the need for housing. Some families have even found the situation so depressing they have expressed that they were better off in refugee camps family reunification; supporting women to know their rights when leaving an abusive partner; reporting safety concerns to the police; finding ways to counter social isolation; and many other requests. This work would frequently be impossible without the use of interpreters. The social worker liaises with a wide range of services including Red Cross, Refugee Trauma and Recovery, Refugee Family Reunification Trust, Wellington Community Law Centre, Strengthening Families, Newtown Budgeting and Advocacy Service, St Vincent de Paul's, Wellington City Mission, and many others.

**Arrivals in the reporting period 1/7/2018 – 30/6/2019**

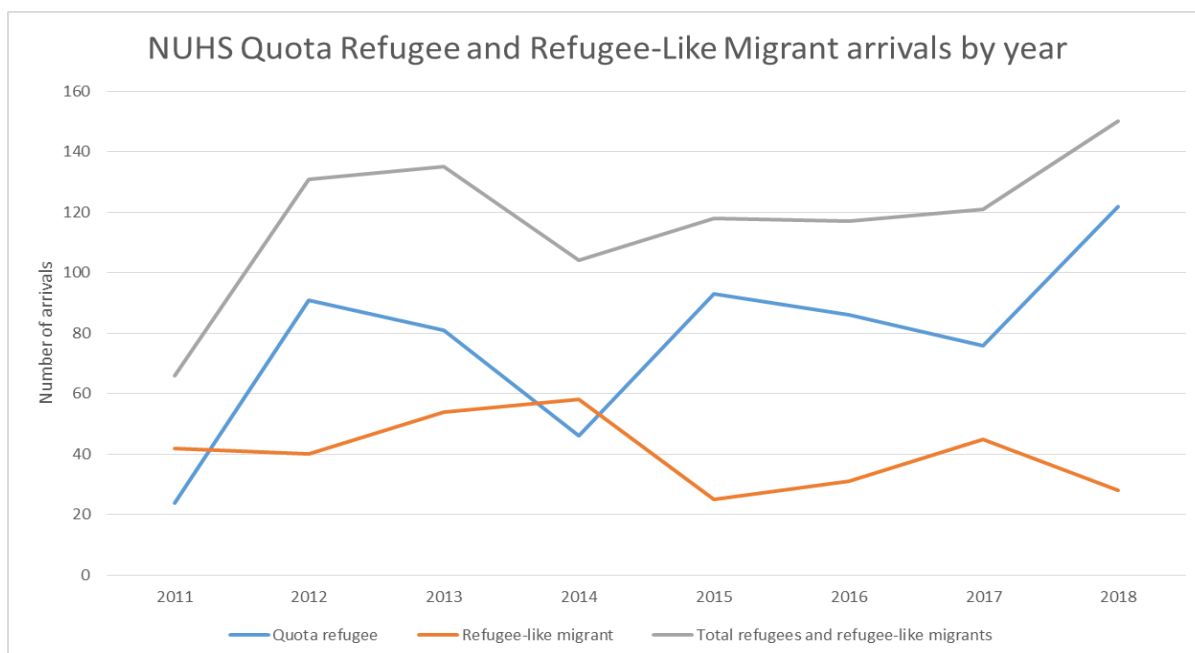


**Figure: NUHS quota refugee and refugee-like migrant arrivals 1<sup>st</sup> July 2018 to 30<sup>th</sup> June 2019 by ethnicity. Note where only one arrival has been identified with a given ethnicity, the ethnicity has been broadened to region to improve anonymity.**

102 quota refugees and 15 refugee-like migrants enrolled and arrived to Newtown Union Health Service in the annual reporting period. The largest quota refugee groups were of Burmese and Colombian ethnicity. The largest refugee-like migrant groups were of Somali and Eritrean ethnicity. Arrivals showed a wide range of ages with the highest numbers in the 10 – 19 years and 35 – 39 years age groups. A wide range of health conditions were addressed for the arrivals.



**Figure: NUHS quota refugee and refugee-like migrant arrivals 1<sup>st</sup> July 2018 to 30<sup>th</sup> June 2019 by age group.**



**Figure: NUHS quota refugee and refugee-like migrant arrivals 2011 to 2018.**

Annual arrivals in the quota refugee and refugee-like migrant groups 2011 to 2018 are provided for reference.

The Newtown Union Health Service refugee team looks forward to providing health care for existing and newly-arrived refugees and their migrant family members in the remainder of 2019 and into 2020.

**Appendix: \*Newtown Union Health Service ‘Refugee-like Migrant’ Eligibility Criteria**

(Also referred to as ‘direct’ refugees, ‘humanitarian’ refugees, ‘family reunification’ refugees)

- From a background comparable to people admitted to New Zealand with refugee status **AND**
- Could be expected to have similar health needs and require screening similar to a quota refugee.

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



### *The Social Worker Team*

#### **Staffing**

Belinda Boyce finished her role as Social Worker in November 2018, when Philippa Thompson returned from extended leave. The Māori Social Worker role has been vacant. Sheree Ryder completed her Year 4 Social Work placement, supervised by Philippa. Sheree confidently fulfilled the expectations of her course and we wish her all the best in her future social work career.

#### **Issues**

Demand for social work support is extremely high. Housing continues to be the most common reason for referral and an underlying issue for many families even when it is not the primary reason for referral. Private housing is frequently unaffordable for those on benefits; there is frequent overcrowding; housing is often of poor standard. The social worker has developed a toolkit to share with families to empower them to self-advocate with housing providers. Other reasons for referral include finances, immigration and family support.

#### **Successes**

It is always a pleasure to hear of those cases where someone has moved into more suitable housing. One such case was supporting sisters to apply for their own tenancy after their mother went overseas.

One young woman with an unrecognised diagnosis was able to access independent housing and support from Community Connections.

#### **Networking**

The social worker benefits from connecting regularly with a peer group of other social workers based in and around Newtown. These monthly meetings facilitate smoother co-operation on behalf of clients when needed.

The Social Worker regularly attends the Refugee Meeting hosted by Newtown Union and has also been able to engage with the Refugee Stakeholder network.

The social worker regularly refers clients to, and receives referrals from, a wide range of other services as needed, including (but by no means limited to), Salvation Army, Wellington City Mission, St Vincent de Paul, Little Sprouts, Refugee Trauma Recovery, Red Cross, Newtown Budgeting and Advocacy Service, Wellington Community Law Centre, Strengthening Families, Plunket, and hospital social work services.

