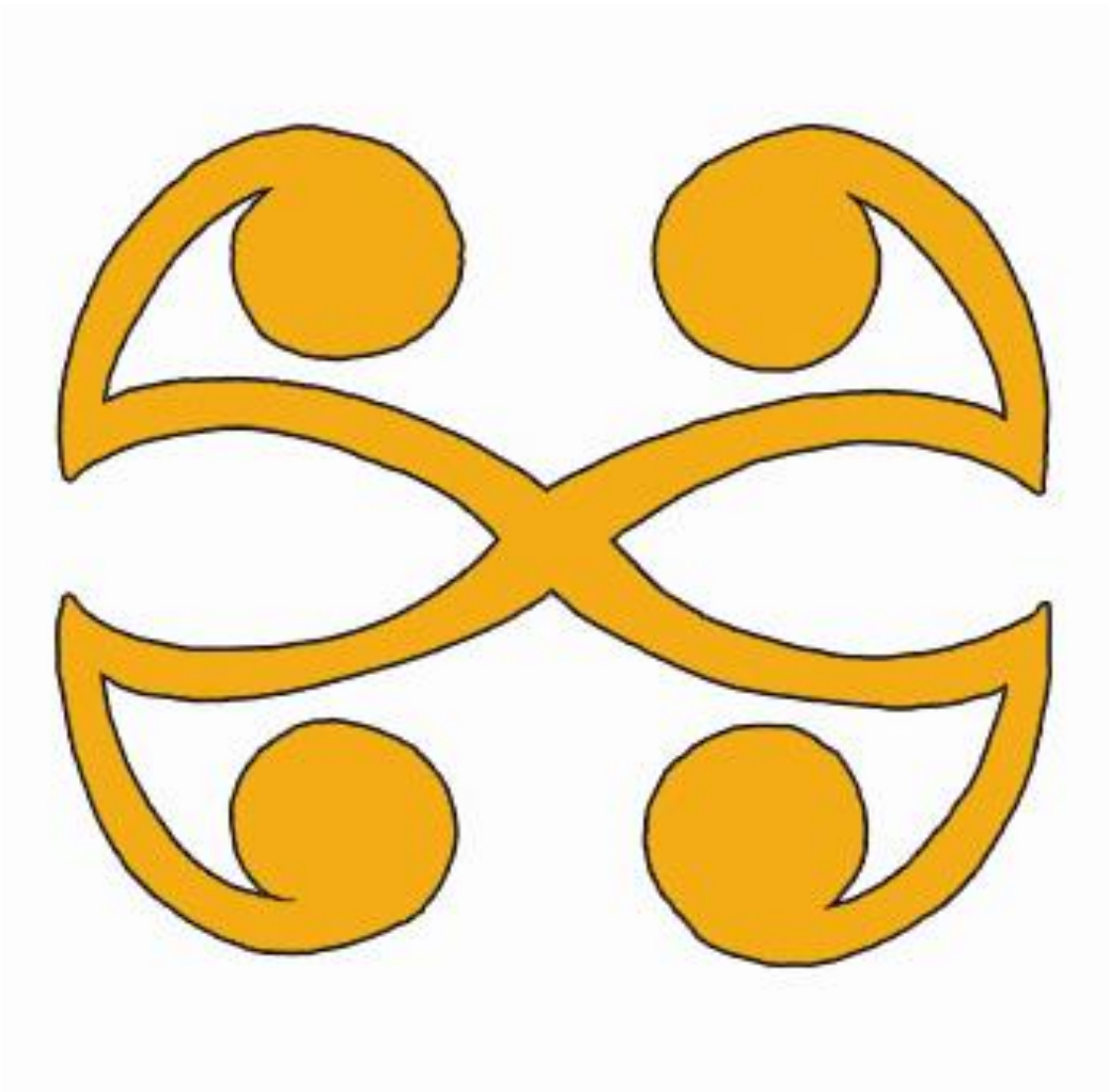
NEWTOWN UNION HEALTH SERVICE

2013-2014
ANNUAL REPORT



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SECTION ONE

Newtown Union Health Service Policy Board and Staff

Policy Board

Chairperson	Eileen Brown
Treasurer	Julie Lamb (Co-opted)
Secretary	Fiona Osten
Kaumatua	Te Urikore (Julius) Waenga
Staff (clinical) Representatives	Pauline Horrill Dianne Theobald
Maori Rōpū Representative	-
Union Representative	Eileen Brown Grant Brookes (joined Feb 2014) James Sleep (resigned Dec 2013) Daele O'Connor (resigned Dec 2013)
Community Representatives	Debbie Leyland Jeremy Rose Eugene Ryder Tina Bennett

Staff

Administration Team	Fiona Osten (Manager), Maribeth Major (Operations Coordinator), Kareena Bryant (PA/ Senior Administrator), Tunisia Pohatu (Clinical Administrator)
Allied Health	Philippa Thompson (Social Worker), Meri Hapu (Maori Social Worker) Stefanie Dōbl (Resigned 15/8/14) Flora Toma (Interpreter)
GP Team	Vivienne Coppell (Team Leader), Jonathan Kennedy, Tin Maung Maung, Pauline Horrill, Katrina Harper, Ben Gray, Victoria Scobie, Nikki Turner, Annie Judkins (Resigned 23/6/14), Andy O'Grady (Resigned 15/8/14)
Nurse Team	Dianne Theobald (Team Leader), Fou Etuale, Bryony Hales, Maureen McKillop, Louise French, Joanne Forsyth, Asha Clark, Delisa Paau (Nurse graduate) Karen Fry, Serena Moran (maternity leave) , Moana Garguilo (locum), Kieran Monaghan (Resigned 8/5/14), Kathy Clark (Resigned 18/10/13), Mary Tohill (Resigned 9/12/13),
Reception Team	Pito Toeleiu, Debbie McGill, Annie Tills, Erin Stewart, Judith McCann, Fusako Kobayashi, Awhina Haerewa (Locum), Penny Tyler (Locum), Josie Bain (Resigned 6/6/14), Seborah Halipale (Resigned 14/3/14)
Inner City Project	Tina Bennett (Team Leader), Janine Hauraki (Administrator), Stephen Jardine, Sonia Smith, Warren Doughty (Resigned 14/4/14), Willie Mailei (Resigned 3/10/14)

SECTION TWO

Chairperson's Report

Tēnā koutou katoa,

It is always challenging to provide low cost, accessible primary health care to people in socially and economically deprived communities. Growing social and economic disparities make that especially challenging. Yet despite these challenges, Newtown Union Health Service (NUHS) continues to deliver quality and comprehensive health services that are valued by our patients, by the wider community and by our many stakeholders.

Being invited to take over the role of NUHS Board Chairperson in December 2013 was a privileged opportunity. Under James Sleep's leadership, the NUHS Board had developed some innovative plans. We built on these this year with our major focus being to produce a strategic plan.

This plan will serve as a road map, establish the priorities and set direction for the next 5 years. Developing this plan has involved meetings with the staff, obtaining feedback from NUHS members, meetings with Ministry of Health and Capital Coast District Health Board officials as well as other critical stakeholders. This has enabled us to gauge satisfaction levels with the performance of NUHS, obtain feedback and gather new ideas. We are fortunate to have had the expert help of Don Hunn, former State Services Commissioner, in working with us on the plan. He has been generous with his expertise and time.

Some interesting insights and issues have emerged from the exercise: the patient's perceptions of NUHS, the staff's view of the biggest issues, the efficacy of our data collection systems, the quality of engagement with the community and our ability to meet the targets for the Service.

Along with all those issues we also have to face the deeply troubling issue of how to respond to the marginalisation of people in our communities because of increasing poverty and growing inequalities?

These are big and complex questions. NUHS has a critical role in responding to these challenges. Our role has always been to advocate for the health and social needs of our people. There are other fundamentals in providing a strong primary health care service; staff must feel valued, we have to manage our data systems well and we must have strong financial management. All of these objectives will be reflected in the new strategic plan.

There is a lot of experience and expertise around the NUHS Board table. My role is to ensure that all the views are heard and considered and to ensure that the service is governed well and upholds the legacy and unique place that NUHS holds in the primary health care sector. I thank all the Board members for their commitment and acknowledge the contribution they make.

I am also very grateful for the skills and expertise of the members of the finance and risk committee: Julie Lamb, Fiona Osten and Giordano Rigutto, who are responsible, along with me, to manage our risks and the financial activities of NUHS. I particularly acknowledge NUHS Manager, Fiona Osten, who provides knowledge and good judgment and ensures the Board are well briefed and informed. Kareena Bryant is the assistant to the Board and her cheerful willingness and hard work are appreciated by everyone.

So as we approach another year which promises to be equally demanding, the words of, *kia kaha, kia māia, kia manawanui, be strong, be brave, be steadfast,* seem very fitting.

Ngā mihi, nui

Eileen Brown
Chairperson NUHS Policy Board

Manager's Report

Welcome to the Newtown Union Health Service 2014 Annual Report. This report is the summary of the last 12 months of service provision from the NUHS team. It provides the reader with some information on the community to whom we provide health services and the work of the team to improve health outcomes for this same group.

2014 has been a full year for the team at NUHS adapting to the changing health environment while continuing to provide quality services based on our members' needs.
This year we have embarked on the first phase of a comprehensive review of the future service direction with the outcome of a Strategic Plan to lead us over the next 5 years. We have been grateful to have Don Hunn guide and lead us through this process and have confidence the changes required will provide sustainability for the service keeping the needs of our community at the forefront.

Over this last year we have been successful and received additional government funding (VLCA) to support the employment of a Nurse Graduate. This has allowed us to grow diversity within the nursing team with the employment of a Pacific Nurse. In addition we also employed a second Nurse Graduate who we were able to secure a positon on the CCDHB New Graduate programme. Although the employment of graduates increases the support required from our existing nurse team it also supports our kaupapa to, where possible, to "grow-our-own" workforce to support our model of care.

There have been changes to how Mental Health Services are being provided regionally, consequently there has been a change to the contract we hold for Peer Support and Advocacy. The contract now covers the provision of advocacy only. The team now provides general community advocacy and advocates for those mental health consumers transitioning into new services. The team continue to work hard keeping the rights of mental health consumers at the fore front.

Over the second half of this year we have introduced communicating information to patients using the text to remind service. While with all new systems and changes there were a few initial teething problems, this has proven to be an excellent tool which we will continue to roll out further during the coming year. We believe this form of communication will further assist us with improving the services we offer to our patients.

This year we were proud to complete our re-accreditation Cornerstone, the Royal College of GP quality programme. This covers both clinic sites, Newtown and Broadway in Strathmore. This current accreditation takes us through to 2016.

There have been many staff changes this year with long-serving staff members moving onto interesting and exciting changes.

Since this time last year we have welcomed Sarah Hewett who has joined the HR team and 2 new staff to our Social work team, Meri Haapu , Māori Social worker and Philippa Thompson. We have had the input of a variety of long term locums in many areas and thank these professionals for fitting into our service, upholding our Kaupapa and taking on the NUHS patients as if they were permanent staff.

I would like to take this opportunity to thank our Kaumatua Te Urikore (Julius) Waenga for his guidance and support to the service and staff. Papa Julius has been part of the service many years and we are grateful for his commitment.

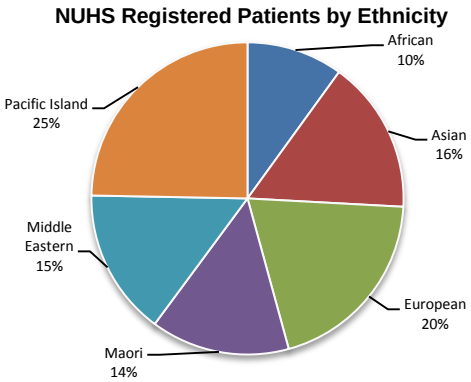
I would like to thank the staff of NUHS for their continued support of the service and the heartfelt dedication they provided to the patients of the NUHS community. Without such a committed and resilient team, the services that NUHS provides would not be possible.

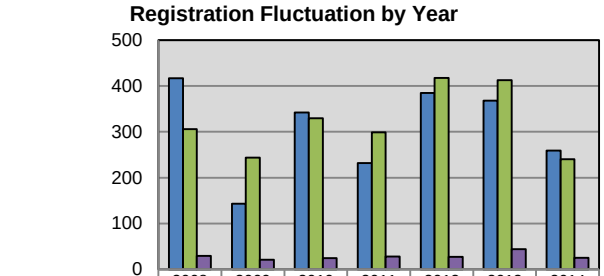
My thanks also go to the NUHS Board and in particular Eileen Brown, who has taken over the role in the past years as Chairperson. Eileen has played an active and full part of the leadership of the Board and towards developing a new and sustainable Strategic Plan. Through this project we have liaised with Community groups, staff, service leadership groups and other informant stakeholders within the community; thanks to all these groups for their support.

Fiona Osten
Manager

Patient Register Demographics Report

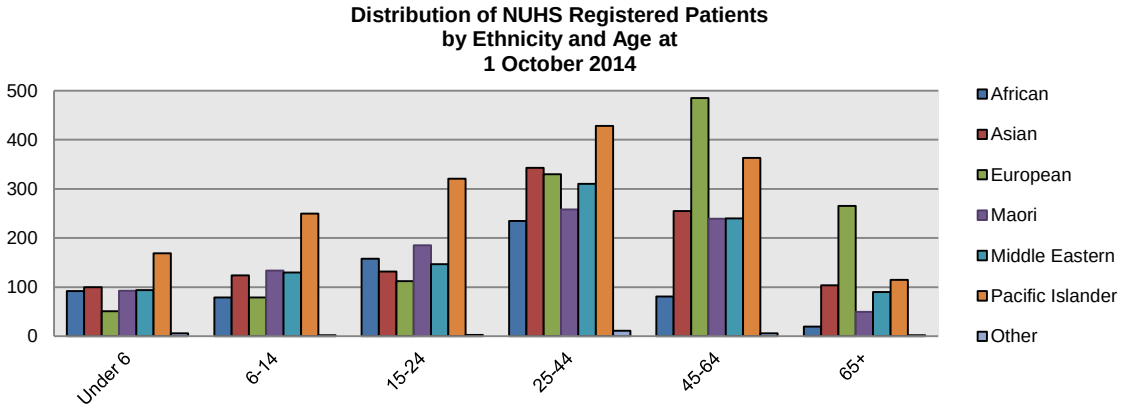
As expected we have seen less dramatic movement again this financial year in comparison to the previous Annual Report. The data analysed in this demographics report gives a snapshot of the NUHS patient register. At 30 June 2014, Newtown Union Health Service has 6669 registered patents and an average of 35 patients per day utilizing the services on-the-day programme.



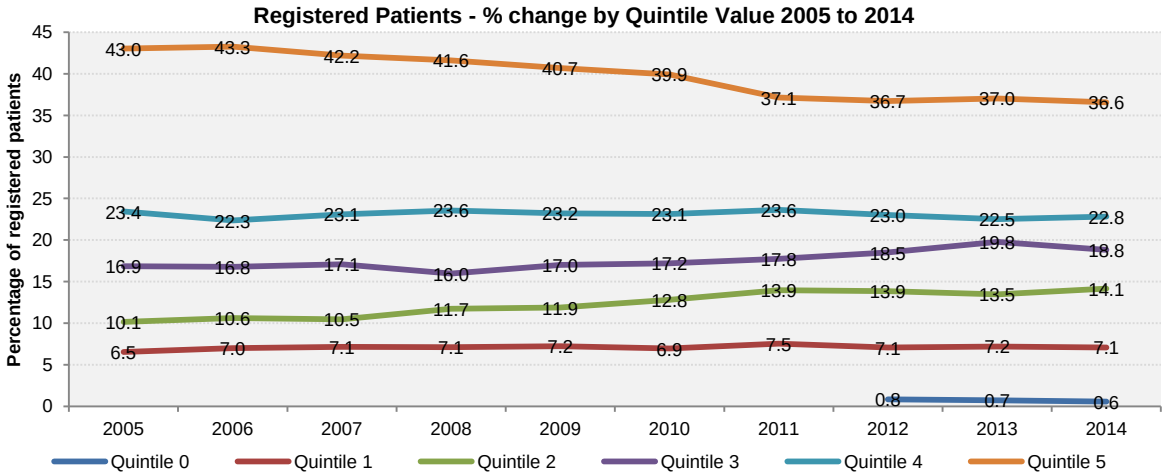


	2008	2009	2010	2011	2012	2013	2014
New Registrations	417	143	342	232	385	368	259
Transfers Out	306	244	330	299	418	413	240
Deceased	29	21	24	28	27	44	25

The 2014 year data (yearly data is recorded January to December) illustrates the first time since 2010 the number of new registrations have exceeded the number of patients transferring out. This shows a positive trend towards growing the register at both the Hall Avenue and Broadway sites.



As at 30 June 2014, the distribution of patients by gender at NUHS is 50/50. The graph below illustrates the breakdown of our registered patients by quintile. The decreasing trend in quintile five percentages can be attributed to patients moving due to social housing constraints and rental affordability within the Wellington South Eastern area.



Note: Due to Ministry of Health changes in the geocoding system within MedTech, 33 patient's addresses are unable to be geocoded.

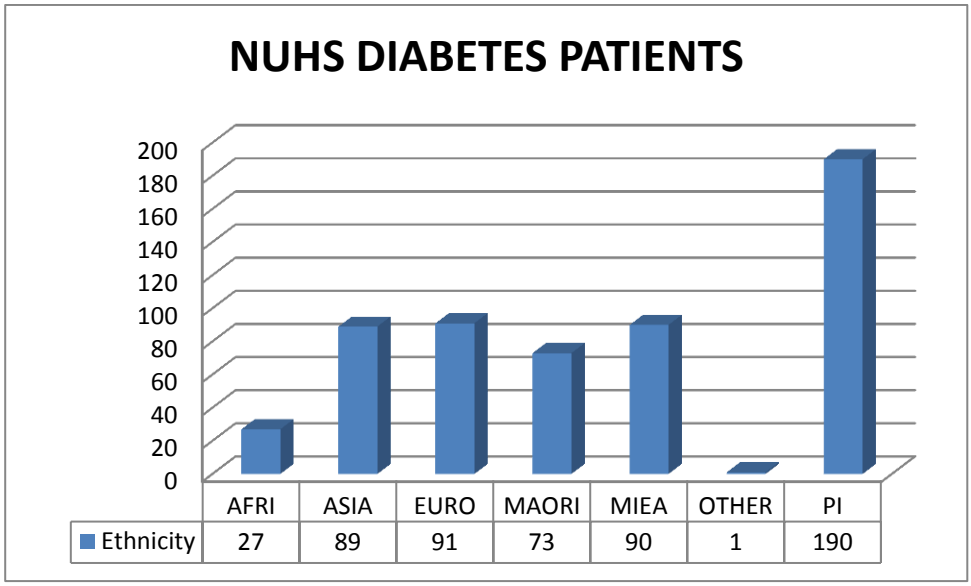
Maribeth Major, Operations Coordinator

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 2013 – 30 June 2014.

Diabetes Team Report

Overview of service activities:
Newtown Union Health Service (NUHS) provides comprehensive Diabetes screening, assessment and treatment service as per our Diabetes Management Plan (DMP).
NUHS has 561 registered patients with Diabetes which is 8.33% of the service population, 625 with pre Diabetes and 30 with gestational Diabetes. Of the registered patients with Diabetes, 23 have Type One Diabetes, 54.9% are within 45 to 64 years of age, 32.8% of the patients are over 65 and 60% have an average of three or more co- morbidities.



The Diabetes Team consists of 2 Doctors, 2 Nurses, 1 Maori Social Worker and an Assyrian interpreter. The team has oversight of Diabetes management within the service and meets monthly to discuss individual case management as well as reviewing current data in relation to our Diabetes register. We monitor rates of annual reviews, retinal screening, numbers of patients on insulin and people with an HbA1c >64 not on insulin, paying particular attention to our high risk populations including Maori and Pacific peoples. Patients with gestational Diabetes are recalled regularly for screening and education by the Diabetes Nurses.
Historically the 2 designated Diabetes Nurses have provided the bulk of diabetes assessments and education in consultation with the patients GP. However as per our DMP, all nurses are receiving further training in Diabetes education. Currently seven nurses have completed the Diabetes e-learning up to level 2 on National Diabetes Nursing Knowledge and Skills Framework (NDNSKF) and 2 nurses are part way through the modules. We have an expectation and strategy in place that all nurses will have completed the e- learning by the end of September. Once they have completed this and gain confidence and experience in Diabetes management, we have a plan to involve the Diabetes Nurse Specialist to provide training and oversight in insulin initiation.

As per the NUHS DMP, nurses provide free appointments 3- 6 monthly or as required for case management of patients with Diabetes. Patients are also entitled to a free Diabetes Annual Review with either their GP or a Primary Care Nurse. Nurses liaise with other allied health professionals i.e. G.P's, Dieticians, Podiatrists and Optometrists to provide optimal holistic care. We continue to offer a regular weekly outreach service at Newtown Park Flats and Strathmore Community Base as well as planned home visits for vulnerable patients. We have a close relationship and provide education and support for the Māori Diabetes Roopu, Te Puna Waiora in Newtown and the Pacific Island, Taranaki group in the central city.
We offer regular as well as opportunistic screening of our high risk populations and are consistently picking up new cases of patients with Diabetes. The numbers of people with Pre Diabetes is also increasing steadily and will present a challenge for our service in the future as to how we will best provide education and management for this group of vulnerable people. We have recently

implemented our protocol for management of people with Pre Diabetes whereby all patients diagnosed with Pre Diabetes receive a letter with an accompanying information brochure on Pre Diabetes. They are offered an appointment with a nurse for education and are put on a recall for 6-12 months depending on their HBA1c.These recalls are actively managed by the nurses to ensure that people are receiving adequate education and follow up.
We continue to hold 3 monthly specialist clinics at NUHS with Dr Jeremy Krebs. On average 3-4 patients are seen each time and we discuss the case management of another 10-20 cases. These are mostly people with a high HbA1c and other risk factors, where we are having difficulty obtaining optimal control of their Diabetes. This clinic has the benefit of providing specialist knowledge to patients as well as increasing the knowledge and skills of the clinicians who host the clinic. As a result of this collaboration the Diabetes nurses in consultation with the GP, manage the initiation and titration of insulin for all our patients commencing on insulin therapy and generally only need to seek specialist advice when targets are not being met. This 3 monthly clinic is very well attended and staff work hard to ensure that people are supported to attend. Patients are encouraged to bring Whanau with them and interpreters are offered as required.
We work closely with allied health services including the Community Dietician, Louise Beckingsale, to provide patient support and education as well as education for staff. Podiatry services are provided at a weekly clinic at Ora Toa Poneke. However due to increasing demand for these services, we are only able to refer people that are considered to be at high risk of developing foot complications. This means there are large numbers of people requiring general podiatry services who are unable to access them due to prohibitive costs.

Retinal screening is generally managed by the nurses. In the last year 449 people have attended the community retinal screening programme and there are many more that are managed by the hospital Ophthalmology Clinic for advanced retinopathy. All are maintained on a regular recall programme through NUHS.

As stated in the NUHS DMP, all patients with newly diagnosed Diabetes are encouraged to attend an appropriate self-management group if available. This is aligned with our philosophy of encouraging all patients to self-manage their Diabetes in whatever way is appropriate for them. Over the years we have tried several times to provide our own group education but our experience has been that these are poorly attended and usually by people who already access services in an appropriate way.
For this reason we do not currently have any formal or structured groups that patients are able to attend. We do however continue to support them to attend any relevant and appropriate support groups within the community.
We currently employ two Samoan Nurses (one who specialises in diabetes), an interpreter who speaks Arabic and Assyrian and have recently appointed a Māori Nurse. These staff members provide valuable support for patients with language and/or cultural barriers. We also hope to improve our access and utilisation of services for Māori with our Māori Social Worker.
We continue to have access to the services of Pacific Navigators through the PHO, Well Health Trust, for assistance in reaching Pacific Island patients who are struggling to make it to appointments both at the hospital and at NUHS. This has assisted several patients to engage more fully with their own care at NUHS.
One of our nurses is currently a Board member of the Wellington Regional Diabetes Clinical Network and has contributed to working groups for the ICC Nutrition Pathway and the development of a self-management group education programme as part of the Diabetes Care Improvement Plan. Both of our Diabetes nurses are members of the Diabetes Nurse Practice Partnership Team and are working hard to ensure that the goals of this group are implemented across the region.

Trends:
As shown in our last report we are seeing increasing numbers of people with Pre Diabetes, deteriorating Diabetes and increasing complexity due to the presence of one or more co morbidities. These people all require additional support to help prevent either the onset of Diabetes or progression to severe complications from their Diabetes.
Another trend is increasing numbers of people starting on insulin therapy. Presently 133 clients are on insulin which is 23.71% of our Diabetes population. This can be attributed to our increased vigilance of HbA1c levels, increased knowledge and confidence of nurses as well as a greater awareness and acceptance of the need for insulin among our communities. While we are encouraged by this trend, it also equates to an increased workload for our nurses as these people require intensive input and support to manage their Diabetes.

Challenges:
An on-going issue and challenge we face is the increasing number of people being diagnosed with Diabetes, the increasing complexity with multiple co-morbidities and the increasing numbers of patients requiring insulin.
We currently have 2 nurses with specialist Diabetes knowledge but we need to increase the skills and knowledge of all of our nurses to provide consistent messages and maintain best practice.
It is widely recognised that group education and 'self-management groups' can provide valuable education and support for patients with Diabetes. We support group education but believe that there needs to be a wider variety of choices available for people to attend.
In the current economic climate it is becoming increasingly challenging to continue to provide a high quality level of care. We are seeing increasing numbers of people with Diabetes and Pre Diabetes and increasing levels of complexity including age, mental health, additional co morbidities', financial hardship and cultural and language diversity. If we are to continue to provide this enhanced level of care to reduce disparity and reduce hospital admissions we need to ensure that adequate resources are available.

Dianne Theobald, Diabetes Primary Health Nurse
On behalf of the Diabetes team

Mental Health Team Report

The NUHS Mental Health team comprises of Dr Pauline Horrill and Primary Health Care Nurses, Asha Clark and Fiona DaVanzo, who provide oversight of mental health services at NUHS.

NUHS, by use of a Mental Health (MH) register, aims to reduce barriers to care, including financial, to those with serious and enduring MH problems to ensure: "Access to quality health care is a human right and people with long term moderate to severe psychiatric conditions, must be provided with accessible, appropriate and quality integrated mental, physical and social/family primary health care adapted as needed to achieve this goal"

As a tool to reach this aim, patients who meet the following criteria are registered onto the 'mental health' or MH register. The MH register helps the MH team to monitor these patients and ensure good quality, timely care. Every year we do a comprehensive review of all these patients to verify they meet criteria and are still accessing the service. We recognised that the diagnoses for being eligible to access the NUHS MH register are identified under Axis I or II, and the individual lives with at least one long term enduring psychiatric condition. This philosophy can be located comfortably alongside any chronic and long-term condition management of a physical health condition.

The role of the MH Team is as follows:
1. Ensuring an inter-disciplinary team approach to good clinical care of patients on the register through weekly team meetings
2. Discussing new registered MH patients at regular meetings and liaising with relevant clinicians to:

- Ensure that on arrival, all new MH register patients have had a full Well Health Check and allocated to a primary nurse and doctor at NUHS.
- Ensure other carers or agencies involved in the care are adequately documented in the MH register template and care plan.
- By ensuring each new MH registered patient has a documented and accessible care plan.
- To identify patients needing early referral to secondary MH care

3. To discuss clinical concerns arising from MH registered patients and by a team approach, identify new approaches required.
4. To provide collegial support, debriefing as required, a review of processes, issues to be discussed in a wider forum.
5. To actively manage the recall system ensuring timely follow-up
6. To be a resource for other staff and other primary health care services regarding issues to do with MH patients.

7. To have input into policy submissions where appropriate and where time permits.
8. To liaise with other services and agencies working with MH patients in the community, to maintain networks and keep up to date with issues for communities and service providers.
9. To be involved in activities promoting mental health and wellbeing for mental health clients and related community development activities.
10. To carry out outreach activities where relevant
11. To maintain an efficient and effective liaison psychology clinic bi-weekly
12. To set and evaluate indicators by reviewing the data from the MH register on a 6 monthly basis

As at 30th June 2014 there were 339 on the Newtown Union Health Service (NUHS) Mental Health register. This number was reduced by six in the last quarter. This figure remains consistently stable as noted in previous reports on this service.

The register is dynamic with a number of exits and new entries according to our criteria of eligibility. There are no significant variations from the last report to comment on, reflecting a stable needs situation but ongoing dynamic use of the program to support new clients with high needs effectively. We highlight once again, the high percentage of this client group being in a higher deprivation index group; thus the need for strong inter-agency coordination and MDT approach.

There are 69 Māori enrolled on the register and 18 Pacific. There are 252 classified 'Other'. We are fortunate to have had Meri Haapu join the NUHS team as a Social Worker focusing on the need of Whanau, Hapū and Iwi. It has been a benefit to connect her informed perspective into the planned clinical care.
Out of the 339 on the Newtown Union Health Service (NUHS) Mental Health (MH) register 32 are on Compulsory treatment orders (12.9%).
Of the 339 on the MH register 61.2% have GP prescribing of their Psych medications and 38.8% prescribed by secondary care.
There are a total of 564 Mental Health diagnoses an average of 1.6 per patient.
Of those aged 45-65, 95% have a documented CVD risk.
The workload remains high and intensive, with an average of 24 contacts per patient over the year
A contact could be a consultation booked, an on the day service, a telephone call, an outreach contact, home visit, hospital visit, or prescription and/or a MDT meeting discussion.

The 26 patients on the MH Register who attend the NUHS Broadway clinic in Strathmore are being fully integrated into the mental health service offered at NUHS, under the coordination of a designated nurse who will liaise with the Newtown based MH team to ensure consistency and quality care across the two sites.

Integrated care model
We have further developed our MDT liaison meeting to include a monthly meeting with Blair Bishop from the Opioid Treatment Service, Peter O'Kane from the CATT team and Monalisa Fanueli from Te Haika. These MDT offer clinical advice on complex issues affecting registered members who may intersect with both primary and secondary services. It has already been beneficial in providing a more coordinated approach to service delivery, with an improved opportunity to minimise conflicting clinical opinion. The goal is to reduce service and service-user confusion, while we work in a more community focused and integrated model.

Alongside the regular contact with secondary and crisis services has been the implementation of Te Ara Pai. It is encouraging to see this service come online to support members of NUHS, with an inclusive and supportive interview process identifying the individual needs and goals. However, we wait to see how the service copes in the coming months as the quantity of referrals is likely to increase. Recent meetings have occurred with the Mental Health team and the team leader of Te Ara Pai, in which we discussed further the role and referral process.

In addition to the NUHS MH liaison role with secondary care, the MH team has also been available for clinical support and information to our fellow colleagues, services such as Inner City Project and Positive Horizons. Positive Horizons offers short-term intervention and packages of care to the 'mild to moderate' members within our PHO. Many of these people are not on the MH Register, but may present with equally complex and risky circumstances.

Main issues and challenges

These remain unchanged and significant issues for our patients, such as:

- Ongoing increasing costs of living – rent, food, prescription charges, alongside other social determinants such as cigarette costs, and alcohol and drug treatment accessibility.
- The ongoing uncertainty of the sustainability of funding across the sector. If greater funding restraints are applied to secondary services, it is likely there will be greater pressure to discharge people back to GP care. Primary Care continues to have minimal access to services such as respite to help support people in escalating crisis. The closure of services such as the day ward has reduced accessible mid-range treatment options for the community; it seems there is either Primary Care or acute, often leading to costly and intensive inpatient intervention.
- The ongoing capacity and sustainability of staff health and wellbeing in these intensifying times.

We end our report with a story of one of our patients to demonstrate MDT care in action.

This person is in his 60's and lives in shared, but unsupported accommodation in the community. He has schizophrenia since many years, is quite stable, but has not seen a psychiatrist for many years. He is attending our clinic quite regularly for check-ups to keep an eye on his physical health as he has asthma. It was noted that he perhaps wasn't coping as well as before as he got older and some question of his mental health deteriorating; we also had some information provided from other community members and agencies. The MH team decided to not only get him assessed by our liaison psychiatrist Paul French to check his current mental wellbeing, but also refer him to Te Ara Pai for a needs assessment to see how he is really coping and what we can do to support him to remain well. The NUHS GP and nurse were involved in the Te Ara Pai assessment, and the Psychiatrist review and we expect to work together to improve his wellbeing again in the community.

Mental Health Team

Strathmore Community Clinic Team Report

Outreach from NUHS to the Strathmore community consists of a weekly Wednesday morning clinic, visits, phone-calls, referrals and documentation associated with this. The Strathmore team comprises Vivienne Coppell (Doctor), Georgie Makamaka (Receptionist) and Elaine Hill (Co-ordinator). Dianne Theobald has been the leading nurse in 2013 with Joanne Forsyth replacing her in 2014. Dr Emily Loan, our Registrar, provided cover from February to June.

The service provides a drop-in service, for acute illness, with some planned follow-up for chronic conditions. We have had a pro-active approach to vaccinate against influenza from March 2014 when this year's vaccine became available.

One of the benefits of working in this outreach environment is having both health and social services available at one site. We hold health promotion days intermittently and have hosted the services of Wellington Community Law Centre (free legal advice) monthly and Budgeting Advice. This is complementary when dealing with the health and wellbeing of people in a holistic model.
We have ongoing discussion with the local pharmacy, public health nurses and the local school (including the new school social worker) as to how together we can improve the health of those in our community.

This year we have offered access to the NUHS patients registered at our NUHS Broadway site as well as in Newtown, and this enables convenient follow-up for tests and reviewing progress.

Our data confirms that the people seen are mainly the priority groups Maori/Pacific, which reflects the local community population.

Dr Vivienne Coppell
Strathmore Community 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 clinic operates every Friday by a nurse, and a doctor attends the first Friday of each month. There are volunteers and the tenants' coordinators who attend weekly for support.

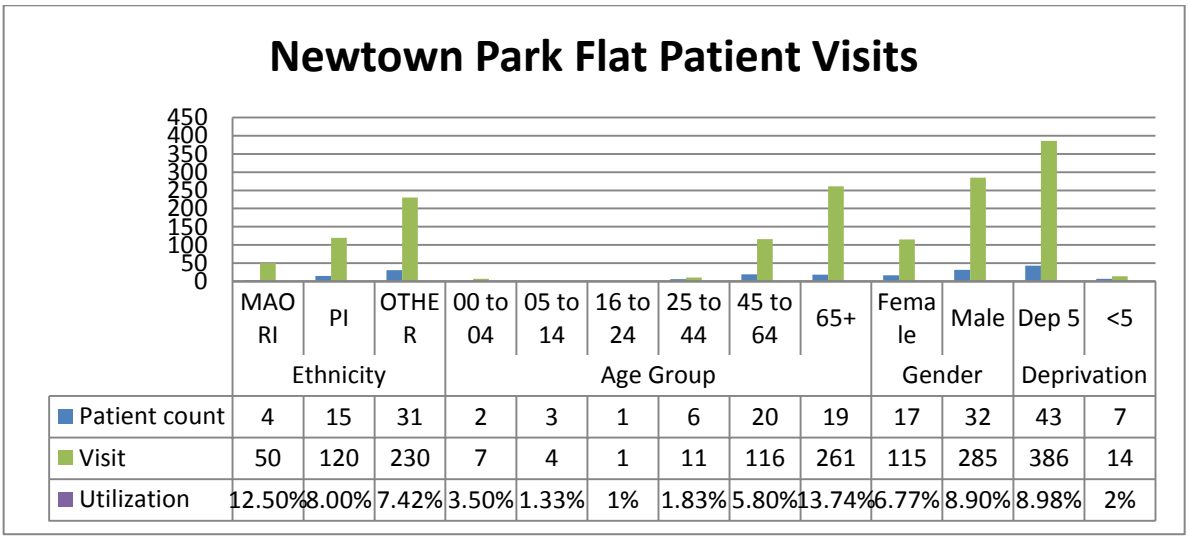
At the end of November 2013, NPF celebrated the opening of the upgraded flats and a new clinic. The purpose-built new clinic is situated in the D Block on the ground floor of 320 Mansfield Street, Newtown. We would like to thank Wellington City Council (WCC) for this great project and their ongoing support from 1987.

The purpose of this clinic is to provide easy access, low cost health care to the tenants and support, aiming at reducing barriers and inequalities to those involved. We deliver medical care including health checks on diabetes, asthma, mental health, sexual health, skin infection and child health checks including immunisation, medication review, blood pressure checks, insulin reviews, social support, health education and promotion on healthy lifestyle and weight reduction support. Clients who request social support are assessed and referred onto appropriate social services.

NUHS Newtown Park Flats Patient Population

	00 to 04	05 to 14	15 to 24	25 to 44	45 to 64	65 +	Total
AFRI	5	1	13	14	3	4	37
ASIA	1	1	1	5	3	6	14
EURO		2	1	2	8	13	18
MAORI	2	2	1	2	3	4	11
MIEA	2	2	1	9	3	7	21
PI	5	4		10	1	7	26
TOTAL	15	12	17	42	21	41	127

The current registered population stands at 127, which has increased from 41 at the middle of last year. This higher figure is due to new clients moving into the newly refurbished Newtown Park Flats. There is significant increase in the number of Africans followed by Pacific Islanders, Middle Eastern, European, Asian and Maori.



	MAORI	PI	OTHER	00 to 04	05 to 14	16 to 24	25 to 44	45 to 64	65+	Female	Male	Dep 5	<5
	Ethnicity			Age Group						Gender		Deprivation	
Patient count	4	15	31	2	3	1	6	20	19	17	32	43	7
Visit	50	120	230	7	4	1	11	116	261	115	285	386	14
Utilization	12.50%	8.00%	7.42%	3.50%	1.33%	1%	1.83%	5.80%	13.74%	6.77%	8.90%	8.98%	2%

Altogether 50 clients made 400 clinic visits during the last 12 months - ie: utilization of 8 per year. Pacific Islanders were the highest users followed by European, Asian, Maori, African and Middle Eastern. Fourteen home visits were made during the same period which has not included in the NPF clinic visit count.

The NPF clinic is utilised by registered patients and casual patients living at NPF and nearby areas. The majority live at the flats and are low income earners with high health needs with complex co-morbidities. Some of the new residents live in isolation and prefer to stay private. Most of the elderly utilise the clinic regularly for health checks and social catch up.

Ia manuia.

Fou Etuale and Dr Tin Maung Maung
Newtown Park Flats Clinic Team

Refugee Team Report

The Refugee Team over this reporting period has consisted of John Sepulveda (RN), Jonathan Kennedy (GP), Stefanie Döbl (Social Worker) and Serena Moran (RN). Mary Tohill (RN) left Newtown Union Health Service during the period. We thanked Mary for her work with the refugee team and welcomed John into the role. Serena provided training, handover and oversight of the changeover.

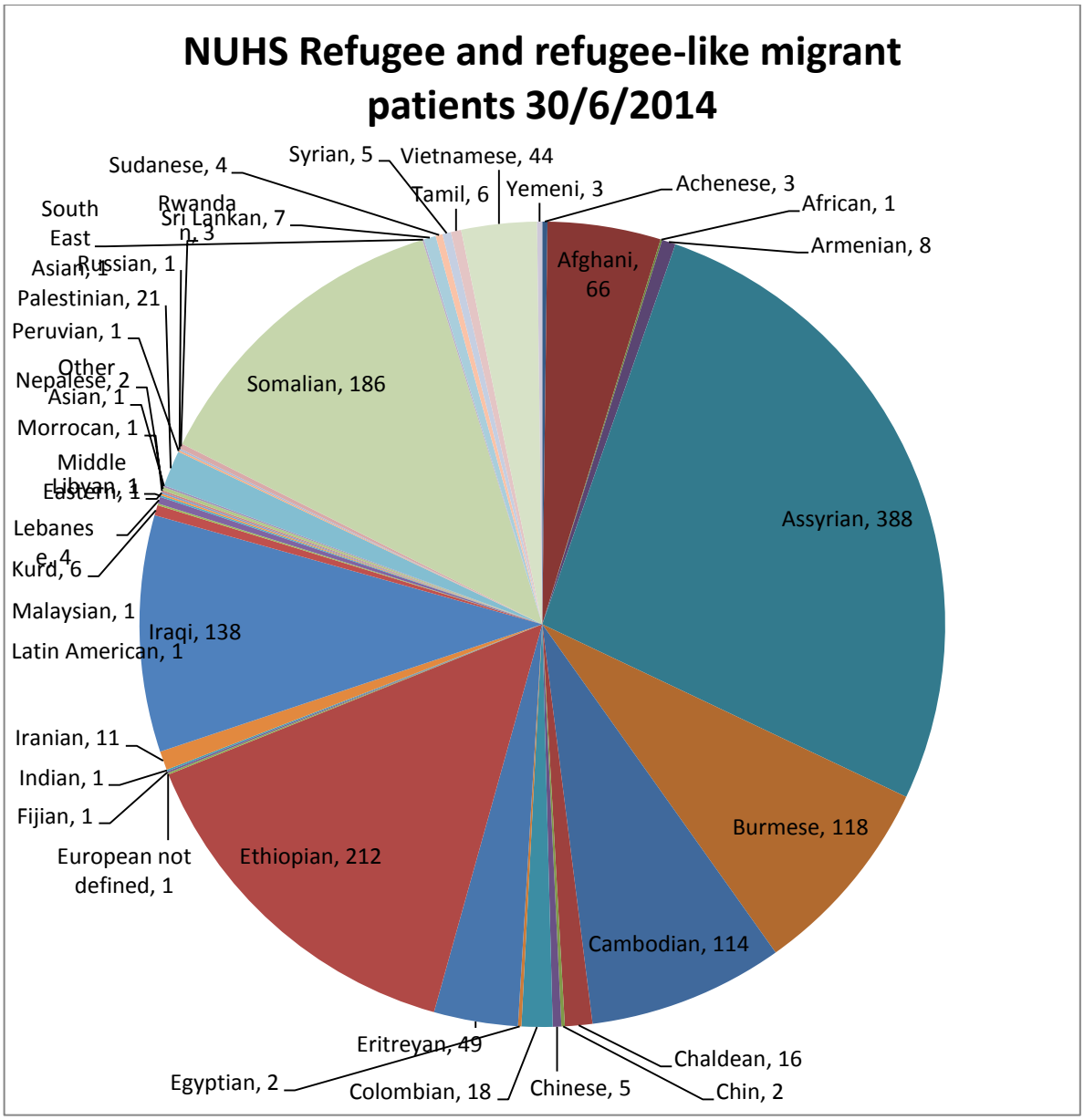


Figure 1. NUHS Refugee and refugee-like migrant patients 30/6/2014

New refugee arrivals

The largest groups of arrivals in the reporting period came from Iraq and Ethiopia, with substantial groups also arriving from Colombia, Somalia, Burma and Sri Lanka.

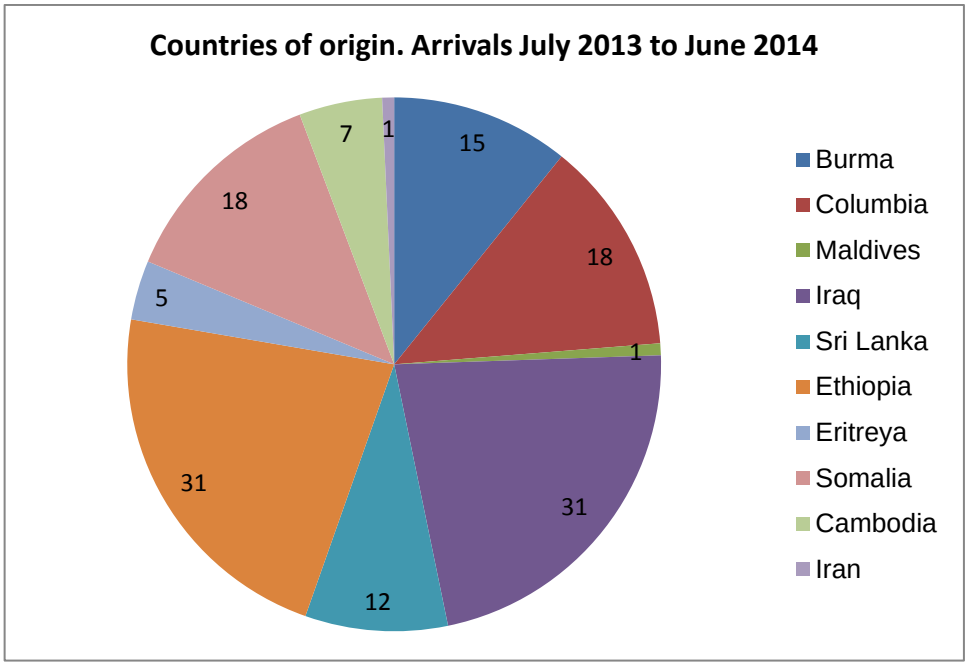


Figure 2. Countries of origin. Arrivals July 2013 to June 2014

All of those arriving from Ethiopia Somalia and Cambodia were refugee-like migrant with most quota refugees coming from Iraq, Burma and Colombia.

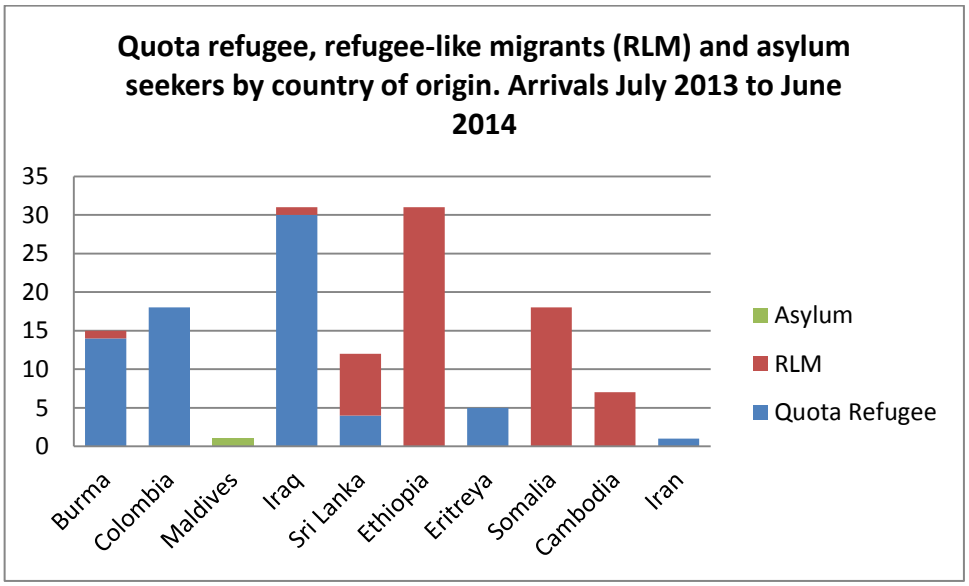


Figure 3. Quota refugee, refugee-like migrants (RLM) and asylum seekers by country of origin. Arrivals July 2013 to June 2014

The refugee like migrants had a comprehensive screening initiated. This was especially important in view of the fact they had not come via Mangere Refugee Resettlement Centre (MRRC). Quota refugees, who had arrived via MRRC required follow-up from their initial screening, which included checking referrals, and completing immunisations, with social work input when required.

Refugee Team activities in the reporting period:

Process for refugee-like migrants

The team have developed and improved the enrolment process for refugee-like migrants. This involved the determination of eligibility for health care funding and simplified the process for our reception team.

1. Proposal for financial arrangements regarding first visits of refugees and refugee-like-migrants to NUHS

The refugee team submitted a proposal to NUHS management in August 2013 to standardise the cost of consultations for newly arrived refugees and refugee-like migrants during the initial settlement period. The proposal was intended to provide consistency and fairness and to more clearly identify the costs to Newtown Union Health Service. The proposal is being considered.

2. GP2GP – electronic transfer of patient notes

The NUHS Clinical Quality Coordinator worked with the Mangere Refugee Resettlement Centre to pilot GP2GP for the electronic transfer of notes for quota refugees. The initial trials have proven to be successful but with some teething problems. We are continuing to work with Mangere to further improve the notes format so that it integrates well into MedTech.

3. Catch-up immunisations

All refugees and refugee-like migrants are asked about previous immunisations and catch-up doses are given when indicated. Planning what is needed in catch-up schedules can be complicated as there are different recommendations according to gender and age. Our clinical Quality Coordinator has worked to clarify how NUHS staff should tailor the catch-up schedules according to the Ministry of Health guidelines and has delivered teaching to NUHS nurses. Most of the offers for vaccination were accepted by refugees and refugee-like migrants. Immunisation outreach nurses were utilized when needed.

4. Presentation to psychiatry Registrars

In October 2013 the doctor and nurse team gave a presentation about Refugee Mental Health to the junior psychiatry registrars for Otago Medical School, with discussion around relevant case studies.

5. Refugees with Disability working group

The NUHS Social Worker actively participated in the Refugees with Disability Working Group in December 2013, run by Refugee Services.

6. National refugee networking day

A joint presentation, delivered by the Refugee team, was given to the National Refugee Networking Day in December 2013, about the Model of Care at Newtown Union Health Service. This day was an excellent opportunity to share information, ideas and connect face to face with organisations involved with Refugee Health and resettlement.

7. Fortnightly liaison meetings

Fortnightly liaison meetings assisted the refugee team and other regional professionals working with refugees and refugee-like migrants, to keep up with changes in the sector and to deal with specific case based problems effectively and efficiently.

8. Improvements to specialist referral processes for quota refugees

The refugee team worked with the Mangere Refugee Resettlement Centre and Regional Public Health to improve referral processes especially regarding refugees with mental health problems.

9. Visit by Mangere programme supervisor

Katrina Penney, programme supervisor, Mangere refugee resettlement centre visited Newtown Union Health Service and met with the refugee team to share news and ideas in June 2014.

10. Presentation to University of Otago postgraduate class

Doctor presented to the University of Otago Wellington GENX 719 Tropical Medicine class regarding refugee health in primary care in July 2013 and then again to the 2014 class in May 2014. Refugee nurse attended the 2014 presentation.

11. Presentation at Royal New Zealand College of General Practitioners (RNZCGP) conference

The Clinical Quality Coordinator and Doctor team developed and facilitated the workshop 'Working with Refugees' at the RNZCGP conference in July 2013.

12. Refugee Trauma Recovery training day

Doctor attended a one-training in working with refuges and trauma at Refugee Trauma Recovery in June 2014.

13. Liaison with Porirua Union and Community Health Service refugee nurse and cross cultural worker.

Doctor met with the refugee nurse and cross cultural worker at Porirua Union and Community Health Service to share ideas regarding primary health care for refugees.

To conclude:

The last year has been busy with patients and with additional activities in the refugee health sector. As always, working with diverse populations has been enriching for all the Refugee Team members and John, who is originally from Colombia, has especially appreciated working with the growing Colombian community.

Refugee team
John Sepulveda, Primary Health Care Nurse
Stefanie Dobl, Social Worker
Dr Jonathan Kennedy, General Practitioner

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*

Social Worker Report

This year has been especially exciting for our profession. It is the first time that the report is written by a social work team as NUHS now employs two social workers.

Introduction Meri - Tena koutou nga Kawana o Newtown Union Health Service.
I commenced employment 21 Jan 2014 as the Māori Social Worker. An important aspect of this role is to encourage and support whanau, hapu & iwi in their journeys toward mauri-ora. Māori make up fourteen percent of patients registered with NUHS, however whanau for a various number of reasons don't visit the clinic unless they are seriously ill. Therefore a significant part of my mahi is to follow-up whanau who have not been to the clinic for two years or more and whanau who constantly DNA. This has been an arduous task, endeavouring to make contact with them.

In an effort to identify barriers and low numbers of uptake I convened and ran a Hui 29/3/14; there has been a slight increase in the number of whanau attending since the Hui.

Kanohi ki te Kanohi is the catalyst for the slight increase in home visits without pre booked appointments. I have found that after a home visit, whanau members are more likely to visit the clinic and access services more frequently. Whanau continue to experience high proportions of social determinants that impinge on their mauri-ora. Currently I have fifty whanau cases, however I would like to emphasise that these numbers are the tip of the iceberg.

I am privileged to work alongside of whanau,hapu and iwi in this rohe. I am totally committed to awhi and tautoko whanau towards Mauri-ora in all aspects of their lives.

Introduction Philippa - I began working here in August. This is my first permanent social work role, having completed a Masters of Applied Social Work through Massey University. I have worked on a short-term contract at Taeaomanino Trust, working with Pasifika peoples in Porirua, and I have a lot of volunteer experience in Wellington community groups. My student placements were at Tautoko Services, supporting people with intellectual disability in the community, and at Wellington hospital, so I am excited to have a role that combines my interests in health and community social work. I'm looking forward to working with you all.

Goodbye Stefanie - I have been the social worker at Newtown Union Health Service (NUHS) for the last 4.5 years. My resignation was not an easy decision, though at the same time it was the right time, as I am able to hand over to two fantastic social work colleagues.
I am very pleased to write my final report for the social work team, as it emphasises the importance of this profession within the wider multidisciplinary team at NUHS. A continuance of the social work support to patients and colleagues at NUHS is also successfully secured.
I much enjoyed my work at NUHS, despite some challenges along the way (which is a normal part of social work). The journey was incredible for me, due to NUHS' patients and staff as well as our colleagues in the community. I appreciated all the welcomes by the people I met over these last few years. Especially the openness, strengths and resilience, as shown by clients I worked with, were and are still inspiring. Lastly, I would like to thank NUHS and my colleagues from the wider community for their ongoing commitment and support to this social work role. Nga mihi nui,Stefanie

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 good outcomes for themselves and their families.

Networking
Our relationships with community and health providers continued to be strong. Such collaborations facilitated timely and smooth access for clients. Our social work peer group at the Well Health Trust PHO ensured ongoing, strong community connections.
Meri Haapu, Philippa Thompson and Stefanie Döbl – Social Work Team

SECTION FOUR

Financial Report

NEWTOWN UNION HEALTH SERVICE INC.

ANNUAL REPORT

FOR THE YEAR ENDED 30 JUNE 2014

1. Audit Report
2. Statement of Financial Performance
3. Statement of Movements in Equity
4. Statement of Financial Position
5. Notes to the Accounts