EAST HEALTH TRUST
primary health organisation

East Health Trust PHO

ANNUAL REPORT

2022

About Us

East Health Trust is a Primary Health Organisation with medical provider teams across the Howick, Pakuranga, Botany, Half Moon Bay, Beachlands, Maraetai, Clevedon & Franklin areas.

We provide healthcare services to 113,526 enrolled patients through our general practice clinics with 100 General Practitioners and over 112 Pracitce Nurses.

Mission Statement

East Health Trust primary healthcare organisation for its enrolled and potential population and community will:

- Ensure that everyone is treated with respect and dignity, their culture is valued and the principles of the Treaty of Waitangi are recognised.
- Endeavour to improve health equity.
- Empower personal and community health & wellbeing by promoting quality information, facilitating innovative programmes and endorsing healthy lifestyle choices.
- Ensure the provision of quality preventative and interventional medical care.
- Enhance the skills and knowledge of personnel and providers.

East Health Trust PHO strives continually to deliver high quality healthcare based on core strategic initiatives, to:

- Improve health and welbeing, especially for those with the greatest health needs.
- Provide a collaborative coordinated response in community health care, including private providers
- Commit to continuously improve quality services.
- Promote utilisation of new technologies.
- Develop and Support the primary care workforce, including promotion of leadership and innovation.
- Secure viability and sustainability of health initiatives.
- Advocate positive lifestyle for all.

Our Values

- Empowerment of individuals, providers and the community to improve health and wellbeing
- Integrity
- Fairness that aims for equity of outcomes
- Respect for the individual
- Collaboration
- Professionalism, skills & knowledge
- Cultural diversity

Contents

Clinical Director's Report

Omicron

Dr Daniel Calder

As we look back on another year gone by, it is fair to say that it has been heavily dominated by Covid-19. The first community case of the new Omicron variant was identified in December 2021 and rapidly became the dominant variant, with multiple waves of infection spreading across the region. As case numbers increased, the emphasis shifted from a Public Health response and contact tracing to a community health response largely handled by GP clinics.

Clinicians had to continuously adapt to rapidly changing guidelines for testing strategy, red & green streaming, and appropriate use of Personal Protective Equipment (PPE).

What really stands out is the unique and powerful connection between healthcare teams and the people that they support. Patient-clinician rapport has often built up over years, sometimes across generations. This meant that when patients received conflicting information from multiple different sources on how to handle covid, they could still seek out reliable advice from their trusted healthcare providers.

Extended Care Teams

The 19 clinics within the East Health network have continued to provide the East Auckland, Franklin and Pukekohe communities with high-quality healthcare services through these challenging times. This has been possible with the combined efforts of colleagues across all disciplines, both clinical and administrative roles. Many clinics have now extended the core clinical team of GPs and Nurses to also include new positions such as Medical Centre Assistants, Health Improvement Practitioners and Health Coaches. They work collaboratively within the wider team and can perform a multitude of functions, including health promotion, early intervention and upskilling for improved mental wellbeing.

Care Plus for Complex Patients

East Health has continued to fund Care Plus for complex patients as a way of ensuring improved access to quality healthcare for people with high health needs. The programme includes extended GP consultations with reduced patient co-payment, fully funded Nurse interventions and encourages interdisciplinary ways of working. Patients can receive single sessions or remain on the programme for longer periods of time where there are ongoing health concerns.

Cervical Screening Campaign

Promoting cervical screening is particularly important at times when some patients deferred their routine screening, whether due to covid related concerns or other competing demands on their time. Fully funded cervical screening during the duration of the campaign has been an effective way of removing cost barriers and act as a 'call to action'. It is particularly pleasing to see uptake amongst women who are overdue or have never previously had a cervical screen.

Sexual Health

Sexually transmitted diseases are a continued concern, and the funded sexual health consults for people aged under 22 years are one of the key ways that East Health mitigates this. Many of the clinics have taken active steps to become youth-friendly and supporting patients with information around issues such as confidentiality and privacy. A young person who does not feel comfortable seeking sexual health services from the same clinic that their parents are registered can get this from another East Health clinic and it would still be fully funded.

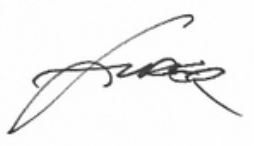
Monthly Spotlight

The monthly spotlight topics have become a way of focusing on key topics such as alcohol brief advice, smoking cessation, diabetes care and cardiovascular health. The spotlight is communicated to the whole network and supported by data from Qlik Data Warehouse. They align well with regional and national clinical priorities, they are generally suitable for individual audits or clinic-wide quality improvement projects.

Educational Activities

East Health has continued to offer a range of educational activities, in-person when this has been possible and via Zoom otherwise. The Continuing Medical Education (CME) and Continuing Nursing Education (CNE) programmes have included a wide range of topics based on the latest clinical priority areas and feedback on topics of interest from the network.

The PHO has also continued providing Self-Management Education (SME) for patients, including Diabetes Self-Management and Mindfulness.



Dr Daniel Calder
Clinical Director, East Health Trust PHO

Our Community

All data as at 30 June 2022

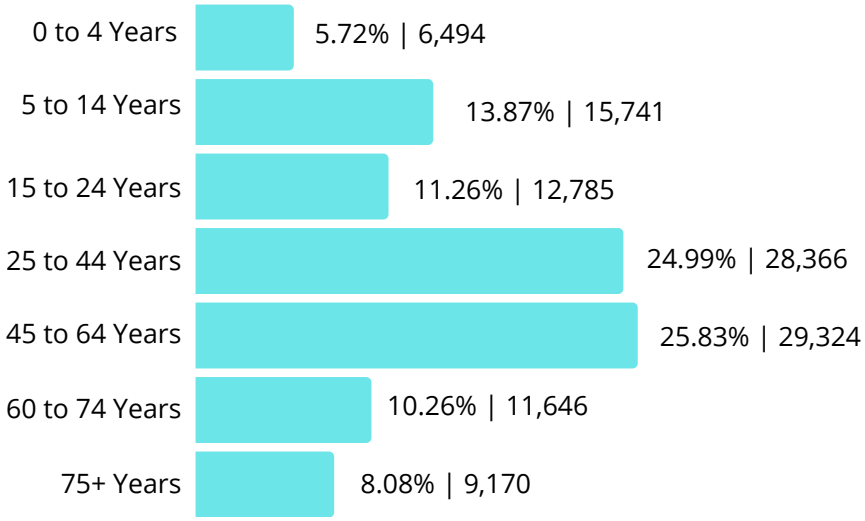
113,526 Total Enrolled Population

15.94% Community Service Card Holders

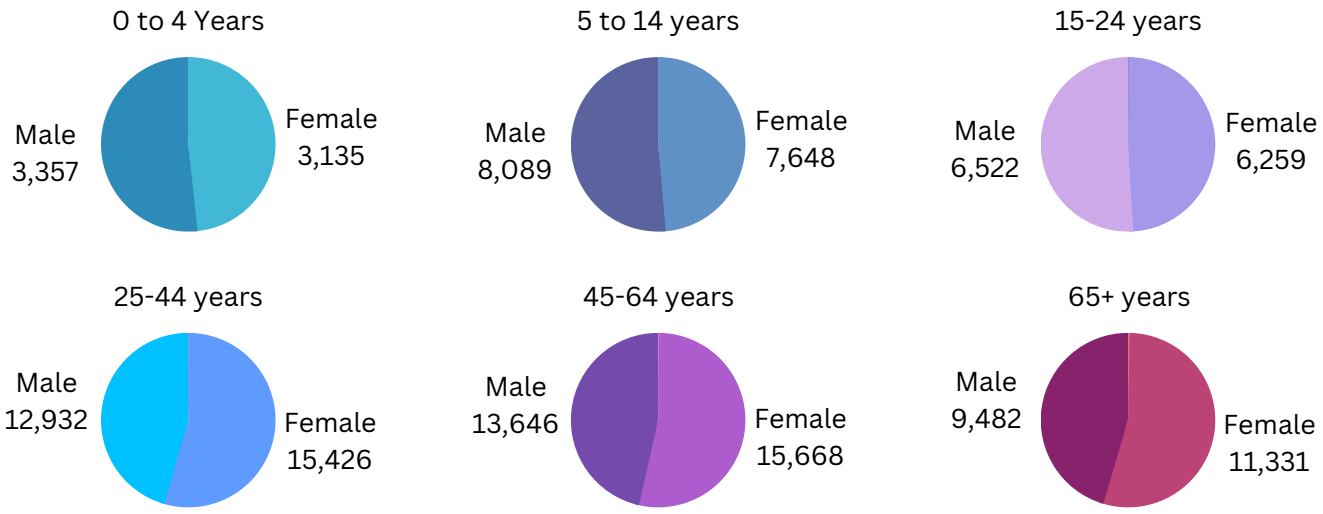
8.91% Quintile 4 Population*

4.28% Quintile 5 Population*

Age Group Profile

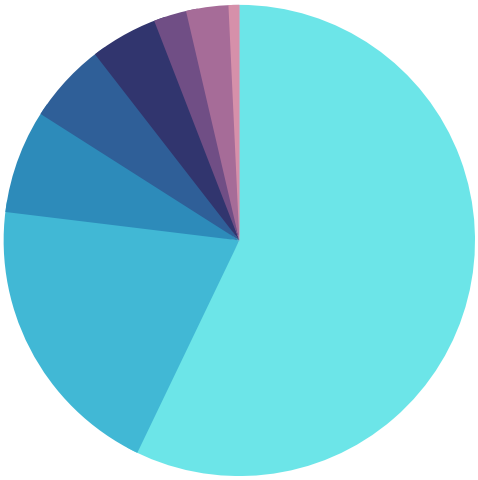


Age Group by Gender



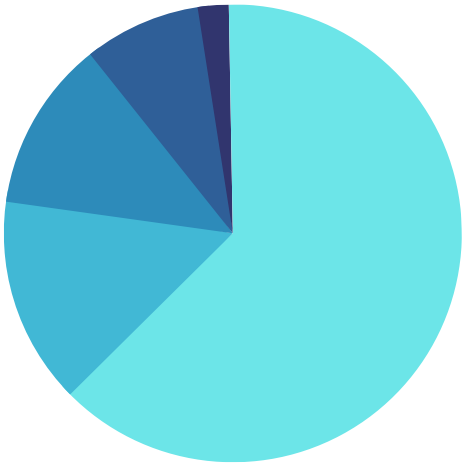
*Deprivation is reported in 'quintiles'.
Quintile 1 represents the least deprived section of the population while quintile 5 represents the most deprived section

Ethnicity Profile



European	57.13%	64, 853
Chinese	19.80%	22,482
Other Asian	7.09%	8,053
Māori	5.48%	6,223
Indian	4.61%	5,235
MELAA	2.25%	2,555
Pacific	2.90%	3,289
Other	0.74%	836

Asian Ethnicity Breakdown



Chinese	62.85%	22,482
Indian	14.64%	5,235
Other Asian	12.08%	4,321
South East Asian	8.25%	2,951
Asian (Not further defined)	2.18%	781

Refugees

This service supports GP and nurse health interventions for people with refugee status as a key component to the wider Counties Manukau wrap-around service aimed to improve the health of refugees and support their settlement into our community.

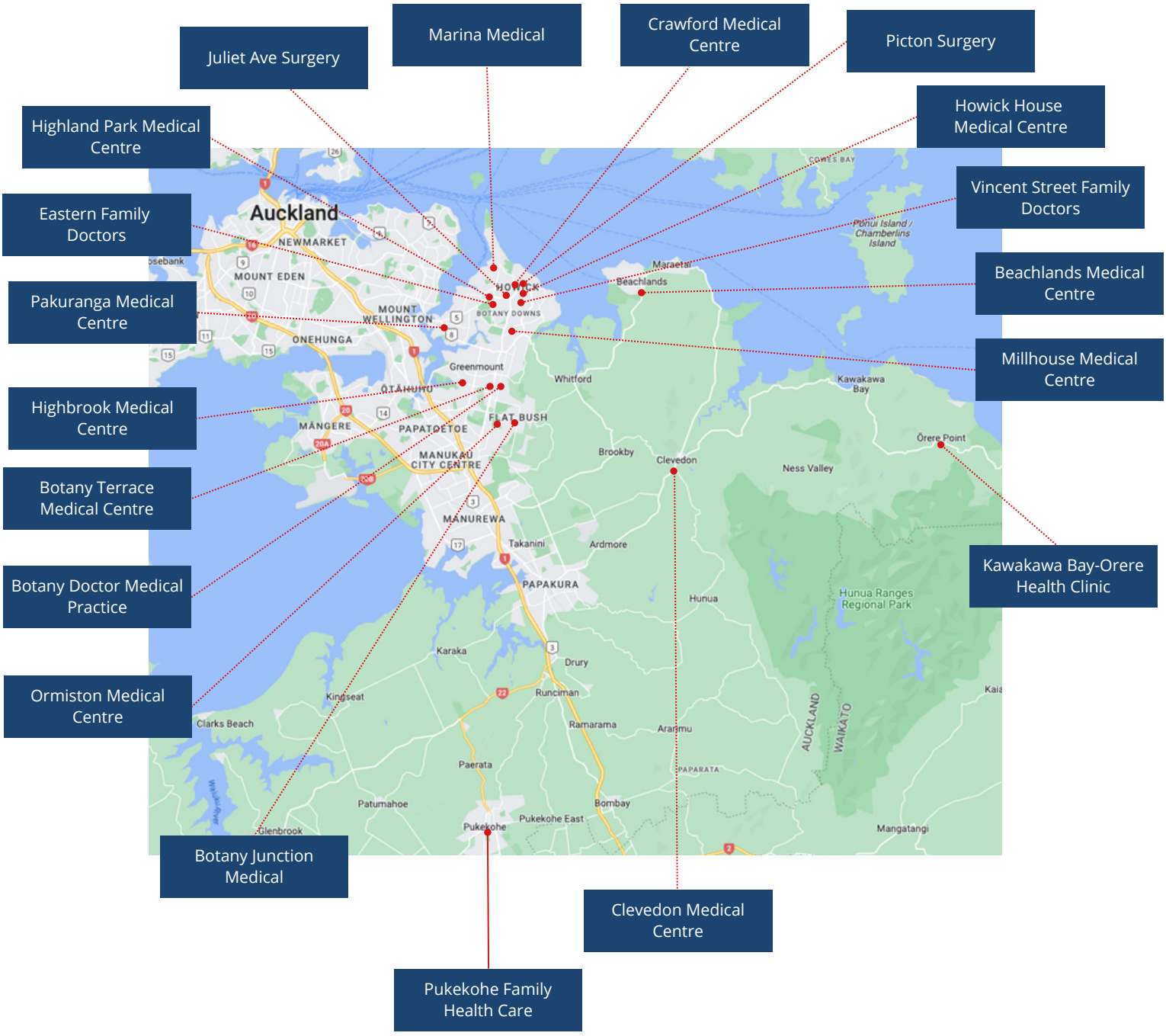
On arrival to New Zealand, refugees often have high health needs due to pre-migration experiences, and this programme enables our general practice teams to provide tailored, culturally responsive health services for early intervention and improved access to essential services.

29 number of refugee patients

92 number of refugee consultations held

Our Practices

East Health Trust PHO represents 19 general practices in the East Auckland and Franklin area with 100 General Practitioners (GP) and 112 Practice Nurses.



100 General Practitioners

66 Full-time equivalent General Practitioners

1720 GP to Patient Ratio

112 Practice Nurses

74 Full-time equivalent Practice Nurses

1534 Nurse to Patient Ratio

Languages Spoken by Clinicians

Afrikaans
Arabic
Aramiec
Cantonese
Chinese
English
Filipino
French
German
Gujarati
Hakka
Hindi
Hokkien
Kapampangan
Korean
Malay
Mandarin
Norwegian
Russian
Samoan
Shanghainese
Shona
South Indian
Tagalog
Taiwanese
Teochew
Punjabi

Foundation Standards Accreditation

The Foundation programme represents a collection of legislative, regulatory, and clinical requirements for all general practices in Aotearoa, New Zealand.
It represents a nationality consistent benchmark by which a practice can measure its current quality of care and progress towards health equity outcomes.

100% East Health practices have achieved Foundation Standards Accreditation

Governance and Leadership

East Health Trust PHO is governed by a team of dedicated and experienced Trustees, Chief Executive Officer and two appointed sub-committees with delegated duties and responsibilities.

Board of Trustees

Dr Brett Hyland (Chair)
David Bryant
Kitty Chiu
Stephanie Vance
Dr Ahmed Kareem
Dr John Betteridge
Dr Richard Coleman

Clinical Advisory Committee

East Health Trust's Clinical Advisory Committee provides clinical leadership, support and governance to the PHOs programmes and health practitioners involved in the care of people in the East Health area.

Dr Daniel Calder (Chair)
Clinical Director, East Health Trust and; General Practitioner, Botany Junction Medical

Cathy Martin
Practice Operations and Quality Manager, East Health Trust

Colleen Bowring
Nursing Director, Health Improvement Group Ltd

David Harrison
Nursing Director, East Health Trust

Jocelyn Meynell
Nurse Practitioner, Highland Park Medical Centre

Dr Simon Russell
General Practitioner, Pakuranga Medical Centre

Karen McCormick
Practice Nurse, Beachlands Medical Centre

Kwee Goh
Clinical Advisory Pharmacist and Clinical Facilitator, East Health Trust

Loretta Hansen
Chief Executive Officer, East Health Trust

Dr Marcus Hawkins
General Practitioner, Botany Doctor Medical Centre

Dr Richard Coleman
Trustee, East Health Trust and; General Practitioner, Millhouse Integrative Medical Centre

Community Advisory Committee

East Health Trust's Community Advisory Committee responds to and provides advice to the board on the community perspective of health, planning and implementation with respect to community initiatives and the provision of health services. This committee is also an opportunity for our community to bring their concerns and suggestions about community health to the Board of Trustees

David Bryant (Chair)
Trustee, East Health Trust and;
Community Representative

Chris Bolton
Disability Representative

Danica Loulie-Wijtenburg
Youth Representative

Jenny Carter
Practice Manager,
Pakuranga Counselling Centre

Zhengxiu Xie
Information Consultant, Independent Living Service Charitable Trust

Kitty Chiu
Trustee, East Health Trust and;
Asian Representative

Lance Watene
Community Advocate, Auckland Council

Loretta Hansen
Chief Executive Officer, East Health Trust

Penelope Frost
Regional Manager, Stand Children's Services

COVID-19 Response

When Covid-19 emerged as a global pandemic, it reached New Zealand in February 2020. Auckland Regional Public Health Services approached the East Health Trust PHO nursing team directly to arrange the swabbing of symptomatic members of the public. Our Nursing team were already fully conversant with infection, prevention and control principles, including the safe use of Personal Protective Equipment (PPE) enabling our team to be first responders to test the public.

Strengthening General Practice

Practice system improvements were implemented as Covid-19 became more widespread in the community. Practices started providing virtual consultations via phone or video and initiating triage services which help reduce the potential risk of infection and breaking down barriers to access to healthcare.

East Health Trust PHO continued to provide daily Zoom meetings with our primary care teams to support their work keeping pace with the evolving nature of the pandemic; these highlighted the latest up-to-minute information being disseminated by multiple health agencies.

On 31 August 2021, Auckland moved to alert level 4. East Health Trust PHO practices stepped up with 17 practices onboarding for the rollout of the Covid-19 vaccination programme. We established Covid-19 swabbing clinics, these clinics were also recognised by Counties Manukau Health as being one of the most efficient in the area. Larger clinics within the East Health PHO network also provided community testing using the red and green stream function, maintaining infection prevention control measures keeping the public and staff safe.

Community-Based Assessments Centre (CBAC)

From July 2021 – June 2022, East Health continued to provide a Community Based Assessment Centre (CBAC) then operating as Community Testing Centres (CTC) at Lloyd Elsmore Park in Eastern Auckland, working to support the Northern Region Health Coordination Centre. The team remained heavily committed to fulfilling the role of Operational Lead, in the East, which included infection, prevention and control training for the workforce as well as education and training in relation to safe clinical practice/ naso-pharyngeal swabbing and donning / doffing PPE.

New Zealand's elimination strategy has been highly successful. The use of public health measures using the alert level systems had allowed us to keep cases, hospitalisations, and death rates very low by international standards. After over 100 days of no community transmission of Covid-19, New Zealand detected its first community case of the Delta variant of Covid-19. Delta, which was much more transmissible, harder to contain and causing more serious clinical illness, started to rise, and Managed Isolation and dedicated Quarantine Facilities availability had reached capacity. As the country transitioned into a new Covid-19 management phase in our national approach to the Delta variant, the Ministry of Health provided pathways out of lockdown to reconnect people together. Once 90 per cent of eligible New Zealanders were fully vaccinated, the Covid-19 Protection Framework would take place, allowing greater freedoms for vaccinated New Zealanders to return to some form of normality.

East Health Trust PHO continued coordinating and supporting services with contact tracing and case investigation.

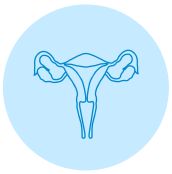
A Year in General Practice

113,526
East Health Trust Total Population

399,777
Number of Consultations by GPs and Nurses

1,067
Number of **Babies Born**

3,402
Babies immunised at 8 months



24,696
Cervical Screening tests completed for women aged 25-69

5,762
Breast Screening tests completed for women aged 45-69

5,335
Patients supported through **Cognitive Behavioural Therapy (CBT), Counselling and Wellness Support**

263
Diabetic patients supported through **Diabetic and Podiatry services**

26,601
Care Plus for Complex Health Needs patient visits

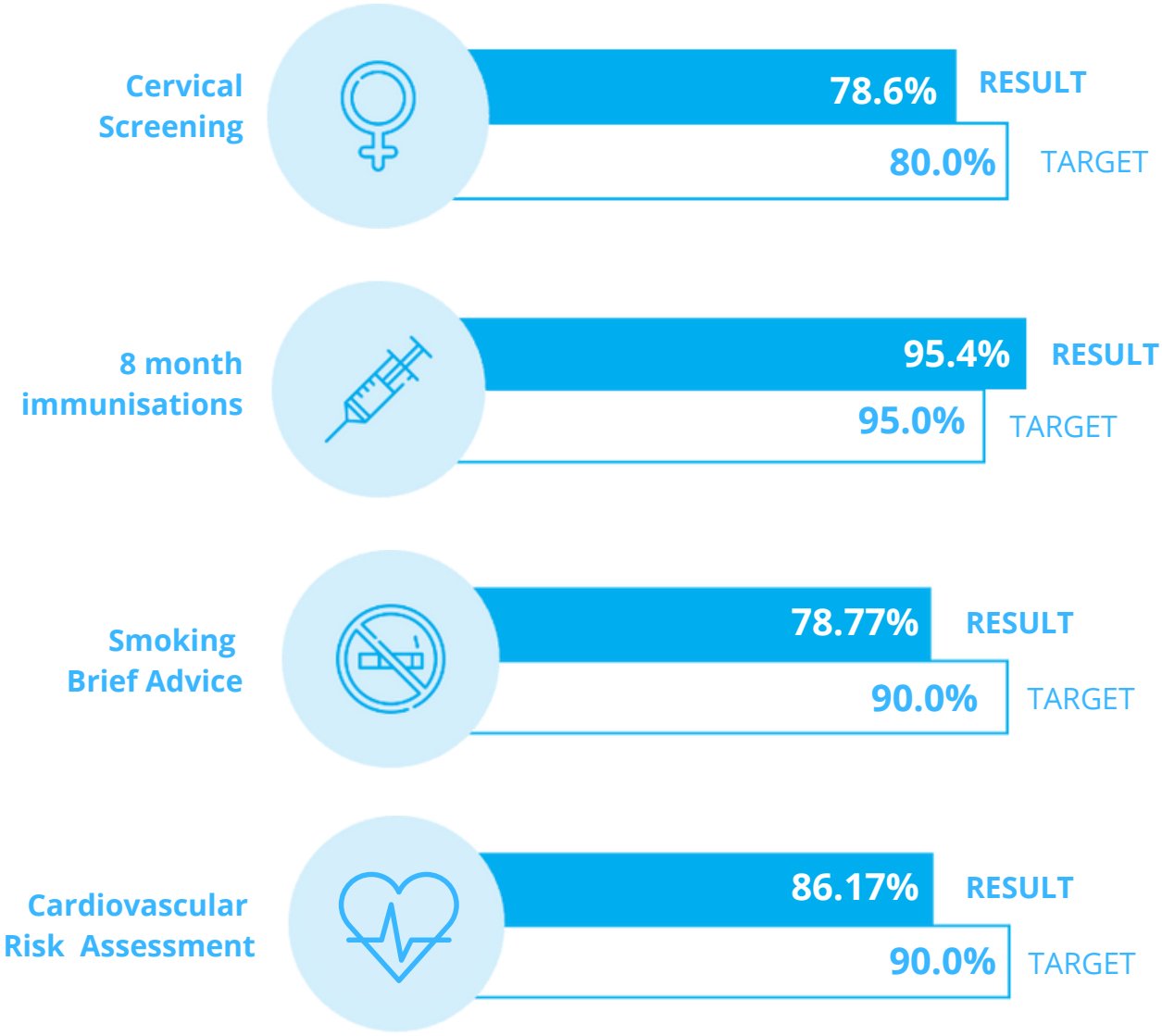
679
Smokers Quit

109
Referrals to **Green Prescription** Health and Wellbeing Programme

Quality Indicators

The East Health Quality Framework for 2021-2022 contained a mix of national health targets and Metro Auckland clinical indicators and remained the same as in previous years due to the uncertainty caused by Covid-19 alert levels 4 and 3. The effect of Covid-19 in the past year has had a profound negative effect on population health measures nationally and particularly in Auckland. There were extremely long periods of reduced activity during the long Auckland lockdown and subsequent Delta outbreak. This is evident in our population health results despite clinics having worked very hard to try to catch up.

- Met the 95% target for childhood immunization rate at 8 months
- Cervical screening rates reduced this year by 0.8% compared to the previous year
- Cardiovascular disease risk assessment reduced by 1% compared to the previous year
- Brief advice for smoking cessation decreased the most, by 10% compared to the previous year.



Supporting Best Care

Continuing Professional Development (CPD)

All education is to ensure primary health care teams have continued access to quality courses and activities to enable them to meet their professional development requirements. We provide a number of professional development opportunities to our practice staff with more use of virtual technologies influenced by Auckland's COVID-19 restrictions throughout this year. Sessions are recorded and available to clinic staff via the Extranet.

PHO practice staff are registered and readily access ongoing education and learning via the e-learning platform through Ko Awatea Learn at Counties Manukau Health. The platform also links to the National e-learning environment across DHBs nationally.

26 number of educational sessions and workshops delivered

379 number of attendees to educational sessions

Alcohol ABC Programme

Together with Counties Manukau Health Alcohol Minimisation advisors, East Health Trust Alcohol champions are partnered with the Counties Manukau Health working group to reduce hazardous alcohol use and minimise the harms of alcohol and achieve equity in key alcohol indicators for Māori, Pacific and communities with health disparities. Ensuring equity in access to high quality and culturally appropriate health care services, in particular, screening for hazardous alcohol use, brief intervention, and referral for treatment when indicated.

East Health Trust Alcohol champion has monthly sessions with the practice champions. It has been encouraging to hear their increased confidence in having conversations about alcohol with their peers and patients. It has been noticeable since embedding the alcohol programme at their respective practices, the statistics provided show a healthy increase in reporting of alcohol-related questions with their enrolled population and applying brief interventions (inclusive of questions from the Audit C assessment tool).
Resources are shared with their colleagues and patients (posters/availability of online resources and leaflets) are visible and readily available. We continue to encourage conversations about alcohol across the practice settings.

Practice champions are encouraged to self-help in attaining alcohol-related resources. Also, keeping up to date with latest research/articles on alcohol-related topics.

Professional Development and Recognition Programme for Nurses

The Nursing Council is responsible for issuing all annual practising certificates to our nursing workforce to provide nurses who work within practices affiliated with East Health with evidence of competency. East Health joined Counties Manukau Health's (CMH) Nursing Professional Development Programme (PDRP), which is accredited by the Nursing Council of New Zealand. This programme meets the competency of the Health Practitioner Competence Assurance (HPCA) Act, 2003. To comply with the programme, nurses are to submit a portfolio every 3 years, which demonstrates competency to practice in their area and evidence of relevant professional development.

East Health Trust's clinical nursing staff are qualified to assess and manage the PDRP programme following the CMH evidence guidelines in collaboration with Te Whatu Ora. Currently, we have 56 nurses employed across the PHO practices actively engaged in the PDRP programme.

The benefits of providing the programme are that it enables East Health to provide support, professional leadership, and growth to nurses. The programme allows the nurse to be part of a locality-wide approach to create standardisation of nursing competency from primary and secondary healthcare nurses. It provides an evaluation of the level of practice within the primary health nursing workforce.

Nursing Education Funding

East Health's Scholarship education fund supports the Nurse Practitioners, Registered Nurses, and Enrolled Nurses employed in our 19 clinics across the East Health Trust PHO in their professional development to ensure the nursing workforce is optimally trained and configured to meet current, and future health needs ensuring patients receive the best health care possible. In addition to the HWNZ funding to support professional development of the nursing workforce, the PHOs Education fund this year has supported:

- Postgraduate University papers to attain Registered Nurse Prescriber qualification
- Long-term conditions management education for a nursing team
- COPD Management Education
- Medication Management Education
- Professional development seminars and conferences

Mental Health Credentialing Programme

East Health, in partnership with Auckland DHBs and PHOs, delivers this valuable training to primary care nurses across the region through Te Ao Maramatanga New Zealand College of Mental Health Nurses.

Every day the primary health care nurse is generally the first point of contact for people with mental health and addiction issues. In having completed the credentialing programme the health care nurse has built on their mental health and addiction tool kit, gaining confidence in normalising conversations about mental health and addiction issues. Nurses screen and assess, deliver brief interventions, support holistic and cultural needs, provide self-care support and introduce patients to other services for support. The wellness support programme nurse-led clinics are showing positive results for the individual practice enrolled populations.

Wellness Support

Wellness Support is the model of care for primary mental health services in the Counties Manukau district. This model has been formed through consultation with primary care health professionals, our community and secondary mental health. The aim is to support GPs and Nurses to work confidently with people to achieve their mental health goals. Our Primary Health clinicians also have, in addition, free access for their patients to psychological and counselling support interventions.

The Wellness Support model now also includes options to use the Te Whare Tapu Wha or Fonofale models, which can be used instead of the traditional screening tools such as PHQ9 or GAD 7 These cultural tools can provide a guide to exploring holistic well-being and may assist with introducing and exploring a person's mental health / wellbeing.

20,759

Interventions of psychology and counselling delivered for the year to 30 June 2022

5,335

People accessed Wellness Support

Enhanced integrated practice teams incorporating Health Improvement Practitioner (HIP) and Health Coach roles.

EHT commenced the roll-out of Health Improvement Practitioner and Health Coach roles as part of a new model expanding the general practice team to include mental health capability, increasing access for patients to self-management and well-being support, health coaches and social supports.

8,500 **appointments with an East Health Trust HIP or Health Coach in the year to 30 June 2022**

"East Health Trust's initial rollout has HIP, and Health Coaches integrated into six practices, working across an enrolled population of over 63,000 people."

These new roles enable enrolled patients experiencing any form of distress to be seen in their local practice quickly – often immediately – by the HIP or Health Coach. Ongoing care of the patient remains with the primary care team, with warm handovers or introductions between members of the integrated team.

This new model of care, Te Tumu Waiora, te reo for 'to head towards wellness and health' is a national collaborative between DHBs, other PHOs and NGOs for a primary mental health system that is more accessible, engaging and connected, supporting people to support themselves and deliver meaningful help when it is needed.

Health Coaches support people with health literacy and self-management. HIPs provide short structured sessions of targeted behavioural health support.

Physiotherapy Services

Otago Exercise Programme (OEP) for Falls Prevention

This 6-month programme is for people 75 years and over (65+ Māori and Pacific people) who have had a fall in the last 12 months and are living independently in the community.

Screening for falls is routine in general practice, and through this year, the effect of the Covid-19 restrictions saw higher rates of people isolating and less active outdoors or in the community. Virtual support opportunities grew, encouraging strength and balance activities in the absence of home visits.

Osteoarthritis Programme

We ran two programmes this year for patients with a diagnosis of Osteoarthritis of the hip and/or knee for one year.

Early intervention in osteoarthritis is vital to improve strength mobility and prevent the weakness that leads to decline and frailty, and falls in ageing.

Patients are empowered and supported to understand their osteoarthritis, learn exercises for home and gym, improve their health status and joint function for a more active future.

Joint Replacement Alternative Therapy

JRAP is for patients with advanced hip or knee osteoarthritis who have been declined for a hip/knee replacement or do not want to have one. Patients are assessed in their homes, and a suitable exercise programme is prescribed along with information about osteoarthritis, pain management, joint protection, cardiovascular activities and weight management. Exercises will progress over the 4-5 month period. Towards the end of the programme, the physiotherapist will suggest and discuss appropriate community activity groups or exercise classes for the patient.

Hydrotherapy Pool Classes

Patients referred to this course are eligible with a diagnosis of Osteoarthritis of the hip and or knee for 1 year.

The programme includes exercise for the home programme, introduction to gym exercise and self-management education, including understanding osteoarthritis, pharmacy and nutrition.

Optimal Precribing

The Optimal Prescribing Programme aims to reduce drug-related morbidity and mortality and improve health benefits through the optimal use of medicines. Clinical pharmacists support patients and practitioners to achieve the best possible outcomes for medication use, health and well-being.

402 **number of medication reviews conducted**

Services include medication reviews with patients, multi-disciplinary team meetings, audits for GPs for particular conditions and education sessions. There are also individual teaching sessions with ongoing support to upskill nurses in best use of medicines, particularly in cardiovascular disease and diabetes care.

Diabetes and Long Term Conditions Management

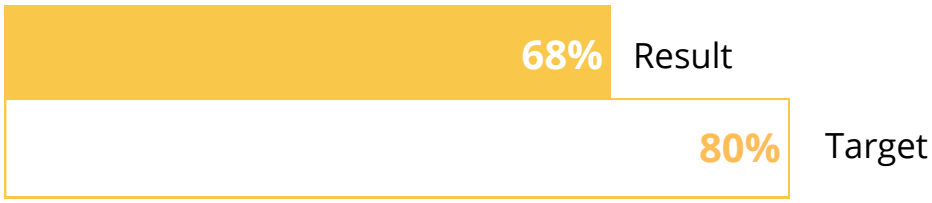
This year's long-term conditions (LTC) programme was heavily impacted by Auckland's Covid pandemic response - alert levels 3 and 4, the subsequent vaccination drives and the treatment of patients with Covid-19. Because clinics were busy supporting these efforts, the usual audits, campaigns and LTC-focused education were paused. Quality indicator reports continued to be sent to clinics each month along with a Spotlight, a monthly communication supporting the Quality Indicators. Seven of the 11 Spotlights distributed were focused on CVD and diabetes. More PHO time was spent improving the usability of the clinic-facing NHI level Qlik Apps.

Supporting People with Diabetes

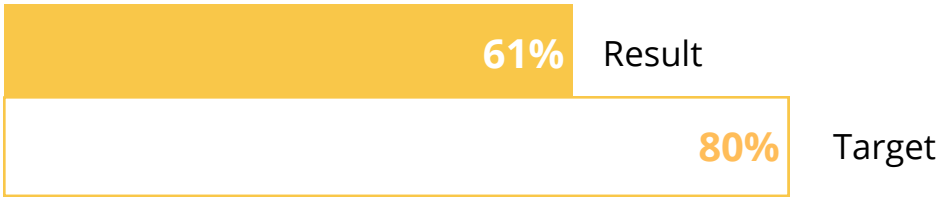
5320 people of our total population of 113,526 have diabetes - 4.7%

For our people with diabetes between 15 & 74 years:

HbA1c ≤ 64mmol/mol



Systolic Blood Pressure ≤ 140mmHg



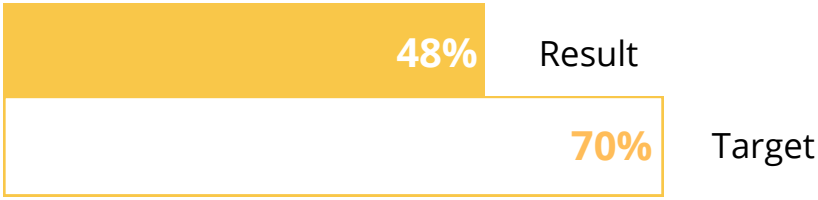
Management or Microalbuminuria with ACEI or ARB

Supporting People with Cardiovascular Disease

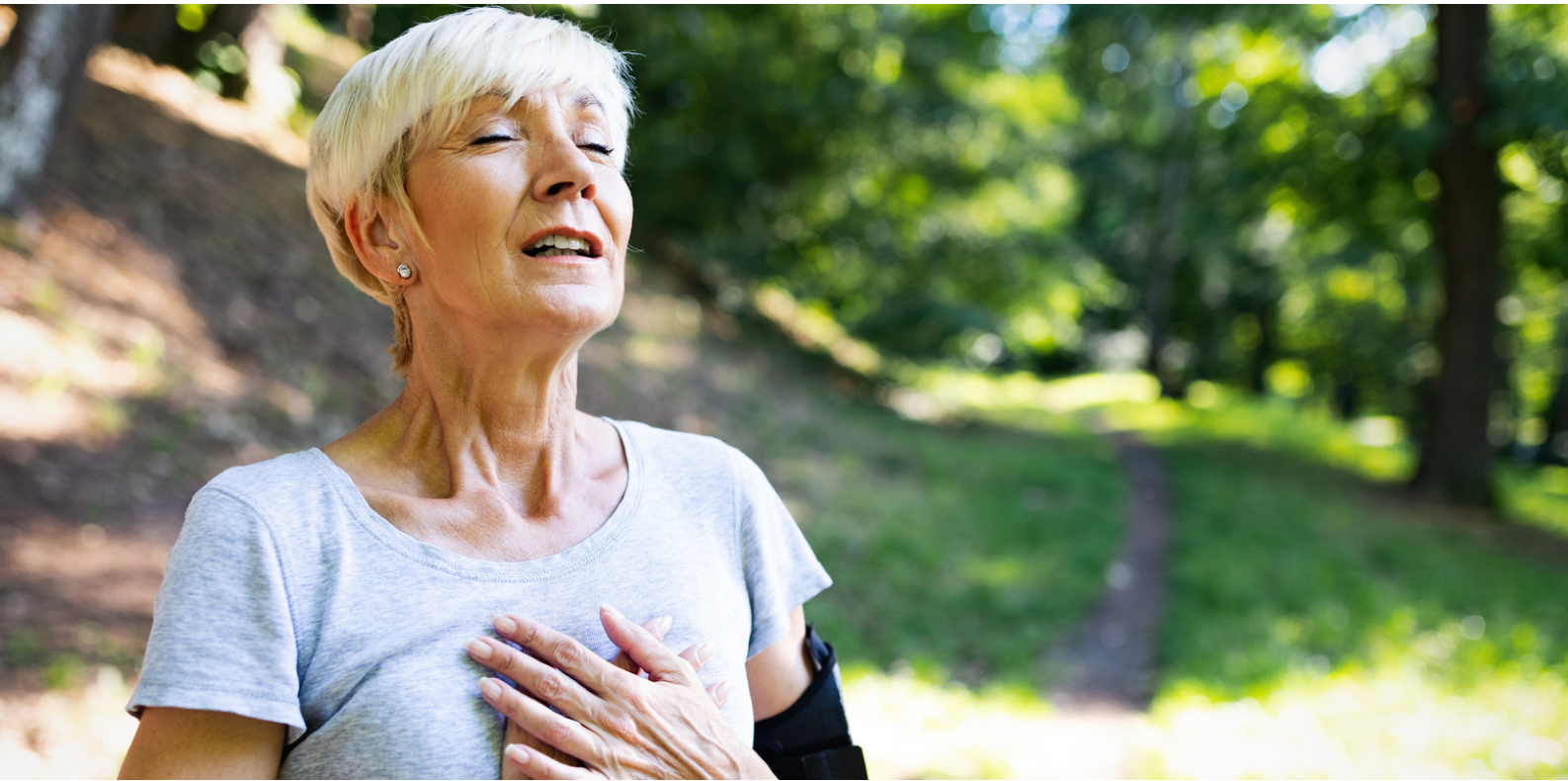
2796 people between 25 and 74 years have either had a CVD event or are at ≥ 15% 5 year risk of an event

Secondary Prevention of CVD treated with Triple Therapy*

Primary Prevention of CVD treated with Dual Therapy**



*Triple Therapy - Statin + BP lowering agent + Antiplatelet/Anticoagulant
**Dual Therapy - Statin + BP lowing agent



Supporting our Older People, and Adults with Complex Health Care Needs, Living in the Community

The Integrated Care Coordinators supported general practice teams to provide better, sooner and more convenient patient care with a focus on older people and adults with complex healthcare needs living in the community. The emphasis was on supporting people to remain safely in the community through a whānau-centred approach. Often the interaction with the person and their family/whānau resulted in connecting them with the appropriate community support group.

This unique and highly responsive role was designed to reduce acute demand and improve patient experience by integrating and coordinating care across Counties Manukau Health. A particular area of work provided clinical support to General Practitioners and Practice Nurses in their care of patients to avoid an acute admission or readmission to the hospital and early discharge.

One of the Integrated Care Coordinators was involved with the Hospital in the Home and Reablement programmes. The Hospital in the home supported early discharge from secondary services with wrap-around care from Middlemore and the Community Health Team. The Reablement programme, based on improving functional rehabilitation to maintain independence, utilised the Community Health Team's allied health staff with nursing intervention as required.

A multidisciplinary approach to clinical care used linkages to the Counties Manukau community and secondary services.
Multidisciplinary Team (MDT) meetings have been held informally to discuss interventions to support patients identified as frequent presenters to the Emergency Department (ED) at Middlemore Hospital.

Reducing harm from falls was another key area where the Integrated Care Coordinators supported general practice in their identification of people at risk of falls and provided links to community-based falls prevention programmes. Referral to the East Health Trust PHO programmes of Otago Exercise Programme, Osteoarthritis and JRAP were encouraged. Where other issues for the patient were identified, the ICCs were contacted for advice, information or home visit.

Services provided by the ICC during this year included:

- Home visits.
- Telephone consultation with patients and general practice.
- Provision of health and social service information to patients and healthcare providers.
- Liaison with the Counties Manukau Health teams.
- Support and encouragement with the uptake of Advance Care Planning with their patients.
- Support and encouragement with the falls prevention screening programme.
- Promotion of the Palliative Outcomes Initiative (Poi) to general practices as a means of increasing the role of primary care teams in delivering palliative care.
- Networking with community-based organisations which support people to live in the community.
- Engagement with the Counties Manukau and Auckland regional services on programme development to support primary health care in the delivery of services to this population group.

Enhanced Primary Care

Care Plus for Complex Patients Programme

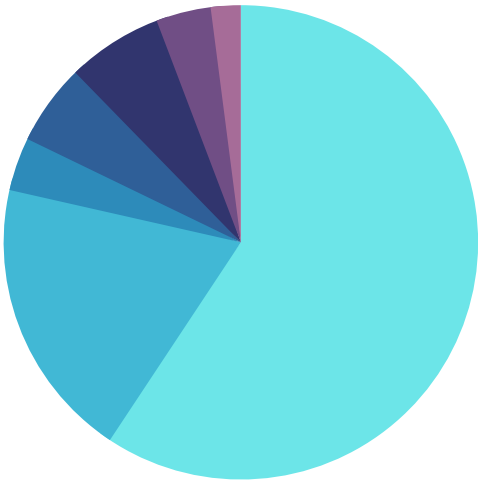
Counties Manukau Health have adopted equity targeting in their approach to supporting people with long-term conditions with their focus on diabetes and improving health outcomes for Māori, Pacific, CSC holders and people living in quintile 5.

6660 **Patients enrolled in the Care Plus programme**

Due to many of our patient population not meeting Counties Manukau Health criteria for services, we developed our own packages of care to enable practices to continue to support people with complex health needs.

The Care Plus model is a patient-centred approach with the primary objective to provide a comprehensive package of primary health care services at a reduced cost for those people who could be identified as having higher health needs.

Care Plus patients by ethnicity



European	3950
Chinese	1281
Other Asian	242
Indian	368
Māori	434
Pacific	249
Other	136

Multidisciplinary Team (MDT)

One of the Integrated Care Coordinators was involved in a District-wide review of MDTs to strengthen and establish a consistent approach across all MDT forums, from informal huddles to formalized Extended Primary Care Led MDTs. Te Whare Tapa Wha was promoted as the preferred model to gather information and create patient-focused interventions.
A training package on the implementation of this model was created and has been slowly rolled out, commencing with the Community Hub teams.

Empowering Nurse-Led Clinics

The New Zealand Primary Healthcare strategy and the New Zealand Health Strategy suggest that healthcare will increasingly rely on providing services aimed at helping patients self-manage their health closer to where they live. As the ageing population and chronic disease prevalence increase, this will cause increased pressure on the health system. To enable a sustainable primary healthcare system, nurses play a pivotal role in providing healthcare within their community. East Health Trust PHO participated in a collaborative research project with The University of Auckland by completing a survey that helped identify key themes that would empower a nurse to thrive at work. Through these learnings and research, our organisation is continuing to support our nurses to practice at the top of their scope.

Nurse-led clinics are nurses working at the top of their scope and providing expert care to people experiencing a range of health issues, working collaboratively with the interdisciplinary team where indicated. There has been increasing evidence demonstrating improvement in health outcomes, cost-effectiveness, and quality of life for people attending nurse-led clinics. We have several blended nurse-led clinics with a total of 17 clinics for paediatric care, woman's health, CVD and diabetes support, travel medicines which are led by Nurse Practitioners, designated and community nurse prescribers, and senior nurses providing nurse-led care for both the management of common ailments as well as long term condition management of patients to include full assessment, diagnosis and prescribing.

East Health Trust PHO supports the Registered Nurse Prescribing in Community Health programme, which improves timely access to medicines for those patients managing common ailments and conditions. This particularly helps ensure our most vulnerable patients have ease of access to quality care delivered by specially trained nurses.

Patient Portals

Patient portals are a secure and convenient online tool assisting patients to interact with their primary care clinic at a time that suits them. This may be booking an appointment to see their GP or nurse, checking lab results or ordering repeat scripts of their long-term medications. More and more patients also have access to patient notes allowing them to check what their GP may have discussed at previous visits.

The patient portals were particularly useful for patients during the recent pandemic when healthcare resources were stretched.

89% **of all East Health Trust patients have access to a patient portal**

92% **of Pacific Patients have access to a patient portal**

93% **of Maori Patients have access to a patient portal**

Data Warehouse and Business Intelligence

East Health Trust is committed to excellence in healthcare for families and whānau in the East Auckland and Franklin areas.

It is our mission to offer the best possible care to our community. Our drive to make continual quality improvements is strengthened by our innovative data platform, which brings together relevant data from all vendor Practice Management Systems (PMS). This central data repository is the foundation for health target reporting, strategic business insights and healthcare planning.

Business intelligence and data visualisation tool Qlik Sense is used by practices to improve the measures within the Quality Indicators and other key clinical areas. All our practices have access to dashboards and report through a secure connection. A significant focus has been on user experience ensuring consistency of design and functionality across existing and new reports.

The dynamic reports in Qlik allow frontline staff to get up-to-date patient health and demographic information, to make informed decisions for better and equitable health outcomes, and to identify vulnerable patients who may benefit from additional care. Principals and managers have access to information to support proactive patient care planning, resourcing and strategic initiatives.

Data (anonymised) for some Quality Indicators feed into matching Metro Auckland clinical indicators allowing comparison between PHOs and give a population view across Auckland.

Continued investment in the Data Warehouse, such as migrating to the 'cloud', will provide further opportunities to support different entities in the changing health landscape. An additional focus is on Cyber Security ensuring best practices to safeguard the data.

Reporting assists our practitioners with:

- Support for patients with Diabetes and Cardiovascular Disease
- Monitoring Flu vaccination uptake by patients 65 years and older
- Access to Cervical Screening results from the National Screening Programme
- Prescribing (antibiotic and other medications) reviews to reduce unnecessary medications and improve health outcomes for patients
- Support to help smokers to quit
- Improved access to primary health care services for individuals with high health needs
- Enhanced utilisation of resources at our clinics
- Capitation and National Enrolment Service (NES) reports.

The project supports:

- Planning aggregate services to meet future population needs
- Identification of individuals at risk of high-impact/high-cost diseases for pre-emptive intervention and proactive patient care planning
- Understanding performance of programmes in achieving health policy goals
- Quality improvement and feedback to individual services
- Timely reports to Health New Zealand.

Alongside our Community

Self-Management Education

Our funded Self-Management Education (SME) programmes support patients and their whānau with the tools to develop their skills, knowledge and increase their confidence to manage their health better and stay well.

182 attendees to Self-Management Education

12 Self-Management Education programmes held

Diabetes SME

This 6-week programme, led by a registered dietitian with input from a registered nurse, is designed to help people living with, or who are at risk of diabetes to maintain/improve glycaemic control and encourage a healthy lifestyle to reduce complications.

Mindfulness-Based Stress Reduction

This 8-week programme incorporates teaching skills of mindfulness, being in the present moment on purpose and responding rather than reacting. Mindful meditation, body awareness and mindful movement are used to support participants.

Mindful Living

A 4-week health promotion programme promoting positive wellbeing through better breathing, mindful movement, benefits of physical activity, healthy eating and more.

Health Promotion in Partnership

East Health Trust partners with local agencies supporting health promotion initiatives to enable people to increase control over and improve their health and well-being. These activities develop healthy lifestyle changes and, together, through community participation, partnership, empowerment and equity, aim to influence and improve people's long-term health outcomes.

Te Tahawai Marae Komiti Marae – Supporting families through Covid-19 Lock downs

Working alongside local Te Tahawai Marae Komiti Marae East Health Trust joined with Auckland Council, local churches, Pakuranga Counselling Centre, Korean Positive Ageing and local food/parcel suppliers to respond to local families impacted by food scarcity during the several Covid-19 lockdowns this year.

This coordinated response resulted in 100s of meals monthly cooked and delivered to families in need.

Te Tiriti O Waitangi

East Health Trust's Health Promotion Coordinator delivers Te Tiriti O Waitangi education to help clinicians in our community develop their cultural competency, their confidence, and understanding of Te Reo and the Tiriti o Waitangi. Sessions held across the community this year with both primary care teams and local pharmacists.

Youth Development

We provide support in schools across our community aimed to develop resilience both with our young people and the teaching staff who work closely with them.

- Facilitated programme of Mindful breathing to reduce stress and calm the nervous system [Botany College staff].
- In collaboration with the Anglican Church's Seasons programme, East Health Trust supports children who have experienced grief and loss, providing coping strategies and an opportunity to be in a group with other young people going through a similar journey. [Bucklands Beach Intermediate, Sancta Maria College, Howick Intermediate].
- PHO representative on the Eastern School's Network, a collaborative for the sharing of initiatives and new activities in our community.
- Connections continue to thrive in this space and are an important area of focus for us to engage with our local young people and the schools they attend.

Asian Community Networking

The Health Promoter is an active member of the Asian Health Network and Asian Health Advisory group as PHO representative, empowering our Asian populations to have a their voices heard, to build their capacity and reduce inequality in health and social services.

Supporting Smokers to Quit

Our Health Promotion Coordinator delivers a range of activities that assist our clinicians and clinic personnel to support their patients to become smoke-free. All patients screened as smokers are offered brief advice and, with consent, referral to Counties Manukau Health Smokefree programme.

- Facilitated a 4-week Quit Smoking programme in conjunction with Counties Smoke-free for our Chinese population in Ormiston [8 out of 10 were smoke-free at 4 weeks].
- Motivational interviewing and telephone support training.

Mindfulness

EHTs Health Promoter raises awareness through presentations of mindfulness (the practice of deliberately bringing attention to present thoughts, feelings and body sensations in a non-judgmental way) on the many benefits of diaphragmatic breathing, shown to improve symptoms of anxiety and depression and help with stress-full times.

- Green Prescription community programme sessions
- Counties Manukau Fire Service Wellbeing Day
- Community Mindfulness presentations, including the local 'Re-thinking Aging' seminar held at Te Tuhi Community Centre.
- Ten, eight-week Mindfulness-Based Stress Reduction programmes delivered, incorporating skills of mindfulness, being in the present moment on purpose and responding rather than reacting. Mindful meditation, body awareness and mindful movement are used to support participants.
- Mindful Living four week programme facilitated at Howick Baptist Home.

456 **people attended presentations in the community to learn about mindfulness in the year to 30 June 2022**


OMRON

Financial Summary

Statement of Comprehensive Revenue and Expenses For the Year Ended 30 June 2022

	Note	2022	2021
Revenue			
Revenue from Non-Exchange Transactions			
Provider Funding		23,113,739	22,079,388
Health Projects		8,145,953	6,418,443
Management Fees		841,068	826,060
Total Revenue		32,100,760	29,323,891
Direct Costs of Services			
Provider Funding		(23,113,739)	(22,079,388)
Health Projects		(8,172,352)	(6,738,345)
Management Fees		(689,672)	(677,164)
Total Direct Costs of Services		(31,975,763)	(29,494,897)
Gross Surplus		124,997	(171,006)
Expenses	3a	(344,885)	(295,393)
Operating Surplus / (Deficit)		(219,888)	(466,399)
Finance Income	4	23,986	40,651
Net Finance Income		23,986	40,651
Share of profit of associates	5	213,200	163,050
Total Surplus / (Deficit) for the year		17,298	(262,698)
Total Comprehensive Revenue and Expense for the year		**$17,298**	**($262,698)**

Statement of Financial Position as at 30 June 2022

	Note	2022	2021
Assets			
Current Assets			
Cash and Cash Equivalents		643,731	402,339
Short Term Deposits		1,502,425	2,200,006
Trade and Other Receivables from non-exchange transactions		1,431,241	367,985
		3,577,397	2,970,330
Non Current Assets			
Investment in Associates	5	980,259	787,058
		980,259	787,058
Total Assets		4,557,656	3,757,388
Liabilities			
Current Liabilities			
Trade and Other Payables from non-exchange transactions		586,887	256,377
Payables to related parties	8	961,322	511,062
Accruals		11,700	9,500
		1,559,909	776,939
Total Liabilities		1,559,909	776,939
Net Assets		**$2,997,747**	**$2,980,449**
Equity			
Corpus		10	10
Retained Earnings		2,997,737	2,980,439
Total Equity		**$2,997,747**	**$2,980,449**

For and on behalf of the Board, who authorised the issue of these statements on 25 November 2022.

Trustee

Trustee

Statement of Change in Net Assets/Equity
For the Year Ended 30 June 2022

	Note	Corpus	Retained Earnings	Total Equity
As at 1 July 2020		10	3,243,137	3,243,147
Deficit for the year		-	(262,698)	(262,698)
Total comprehensive Revenue and Expense for the year		-	(262,698)	(262,698)
Balance at 30 June 2021		**$10**	**$2,980,439**	**$2,980,449**
Surplus for the year		-	17,298	17,298
Total comprehensive Revenue and Expense for the year		-	17,298	17,298
Balance at 30 June 2022		**$10**	**$2,997,737**	**$2,997,747**

Statement of Cash Flows For the Year Ended 30 June 2022

	Note	2022	2021
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash was received from:			
Funders		30,983,500	29,283,003
Interest		22,857	44,320
Goods & Services Tax		55,133	-
		31,061,490	29,327,323
Cash was applied to:			
Suppliers & Employees		31,537,679	29,676,794
Goods & Services Tax		-	54,534
		31,537,679	29,731,328
Net cash received from / (applied to) operating activities		**(476,189)**	**(404,005)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Cash was received from			
Dividends from associates	5	20,000	12,000
Proceeds from termination of term deposits		697,581	366,790
		717,581	378,790
Net cash from / (applied to) investing activities		**717,581**	**378,790**
Net cash received (paid) for the year		**241,392**	**(25,215)**
Cash and cash equivalent balance at 1 July		**402,339**	**427,554**
Cash and cash equivalent balance at 30 June		**$643,731**	**$402,339**

Statement of Cash Flows For the Year Ended 30 June 2022

RECONCILIATION OF NET SURPLUS TO CASH FLOWS FROM OPERATING ACTIVITIES

	Note	2022	2021
Reported Surplus / (Deficit) for the year		17,298	(262,698)
Non-cash items: - Share of loss (profit) of associates	5	(213,200)	(163,050)
		(195,902)	(425,748)
Movements in working capital items:			
Accounts Receivable		(1,118,389)	(146,287)
Accounts Payable		782,969	113,496
Net GST		55,133	54,534
		(280,287)	21,743
Net cash received from operating activities		**($476,189)**	**($404,005)**

East Health Trust PHO
Annual Report 2022

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