EAST HEALTH TRUST
primary health organisation

East Health Trust PHO

ANNUAL REPORT

2020

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 and Manukau areas.

We provide healthcare services to 95,036 enrolled patients through our general practice clinics with 87 General Practitioners and over 80 Practice Nurses.

Mission Statement

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

- 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.
- Ensure that everyone is treated with respect and dignity, their culture is valued and the principles of the Treaty of Waitangi are acknowledged.

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

- Improve health and wellbeing especially for those with the greatest health needs.
- Provide a collaborative coordinated response in community health care.
- Commit to continuously improve quality services.
- Promote leadership and innovation.
- Develop and support the primary care workforce.
- Secure viability and sustainability of health initiatives.

Our Values

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

Declaration of Astana

East Health Trust PHO fully endorse and commits to the World Health Organisation's (WHO) Declaration of Astana

Key Messages

We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind.

We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social wellbeing, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals.

We acknowledge that in spite of remarkable progress over the last 40 years, people in all parts of the world still have unaddressed health needs. Remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations. We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.

We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. We will promote multi-sectoral action and UHC, engaging relevant stakeholders and empowering local communities to strengthen PHC. We will address economic, social and environmental determinants of health and aim to reduce risk factors by main streaming a Health in All Policies approach.

PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care - the first contact with health services - prioritising essential public health functions. We will prioritise disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive prevention, promotive, curative, rehabilitative services and palliative care.

To read the full WHO Declaration of Astana, go to:
who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

Contents

Clinical Director's Report

Dr Daniel Calder

This year has been marked by the Covid-19 pandemic and the extraordinary response by primary care to safeguard our communities. The first case of Covid-19 arrived in New Zealand on the 28 February 2020. Shortly thereafter, one of our clinicians suspected Covid-19 in a patient. After navigating complex testing rules, the GP managed to secure a test for this man who turned out to be the third case of Covid-19 in the country. Early learnings from this were shared within the East Health network and beyond. This and other cases identified in primary care eventually led to a broadening of the testing criteria.

Keeping informed

As Covid-19 emerged as a new and concerning condition, Zoom became an effective way of disseminating information to our affiliated practices and getting rapid resolution of issues. East Health collaborated closely with partners from the Ministry of Health, Counties Manukau DHB, and the Northern Region Health Coordination Centre.

Call to action

Saturday 21 March 2020, just three weeks following the first COVID-19 case, the Royal New Zealand College of General Practitioners (RNZCGP) requested all GP practices in the country to immediately adopt virtual triage for all patient contacts and aim to provide most consultations by virtual means. East Health supported this call to action from the College and our clinicians rapidly implemented virtual healthcare. Importantly, all our practices continued seeing patients in-person whenever clinically indicated and there were no practice closures that took place within our network.

Elimination strategy

East Health staff were directly involved in supporting the elimination strategy by setting up a Covid-19 testing facility established on-site in Spectrum House. This was a major undertaking and commitment as many of our key personnel contributed to this over long periods of time. Additional Covid-19 swabbing capacity was established in many of the practices and there was a continued focus on infection control to ensure optimal safety for both staff and patients.

Deferred outpatient appointments

There was growing concern from our network regarding deferred outpatient appointments and prolonged waits for elective surgery. Hospitals were standing up dedicated covid-19 wards and prioritising intensive care capacity. Primary care colleagues were at this early phase of the pandemic faced with stricter acceptance criteria for referrals and heightened focus on early discharges, resulting in increasingly complex patients receiving their care in the community.

Health Information Technology

Regional stakeholders, including DHBs and PHOs committed to a shared primary care health record called 'Your Health Summary' (YHS). This was set up to allow sharing of health information by authorised healthcare providers that deliver care for that person in a range of care settings.

YHS can benefit the most vulnerable in our population who do not always receive care for health conditions from the same provider, and those who access the health system under emergency circumstances, such as Covid-19. Many of the East Health practices were early adopters of this system.

Several of our affiliated practices also changed their Practice Management System (PMS) to Indici, by Valentia Technologies. This was a major undertaking and required significant input from the data analysts. Good quality population health data is one of the key strengths of East Health and this is in part enabled by our advanced Data Warehouse.

Primary and Secondary Care Interface

The administrative burden in Primary Care is rapidly increasing and contributes directly to staff burnout, thereby risking both workforce recruitment and retention. East Health identified that much of the administrative load originates from outside of the practices and improvements could best be achieved by a collaborative approach between stakeholders. A small group of PHO representatives met the Chief Medical Officers from the regions 3 DHBs and this resulted in a regional forum for considering interface issues.

Preventative healthcare

Achieving equity and best possible health outcomes is one of the primary objectives of East Health Trust. Continuing to perform well on preventative healthcare outcomes during this global pandemic is therefore a priority. We have managed to maintain a clear focus on health promotion through our strong links with frontline clinicians and strategic use of population health data. In a situation where Covid-19 brings much uncertainty, it is essential that we can support clinical colleagues to work in partnership with their patients to achieve optimal health for all.

Dr Daniel Calder
Clinical Director, East Health Trust PHO

Our Community

All data as at 30 June 2020

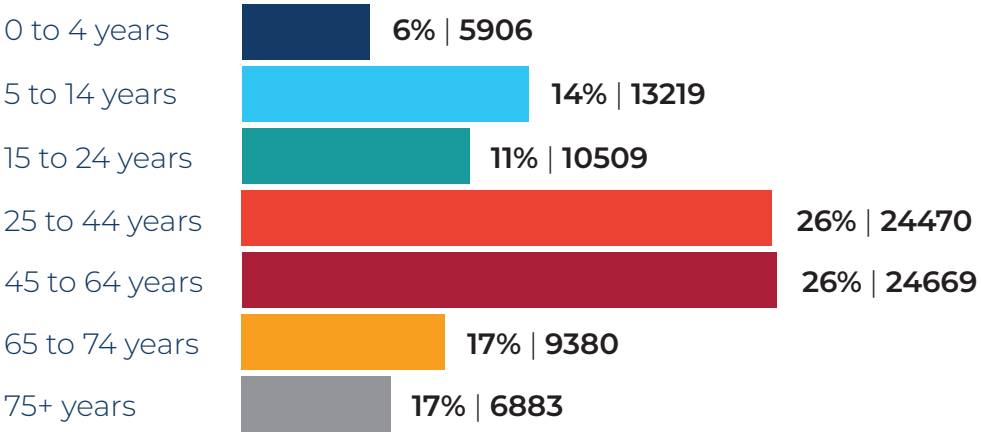
95,036 Total Enrolled Population

14.06% Community Service Card Holders

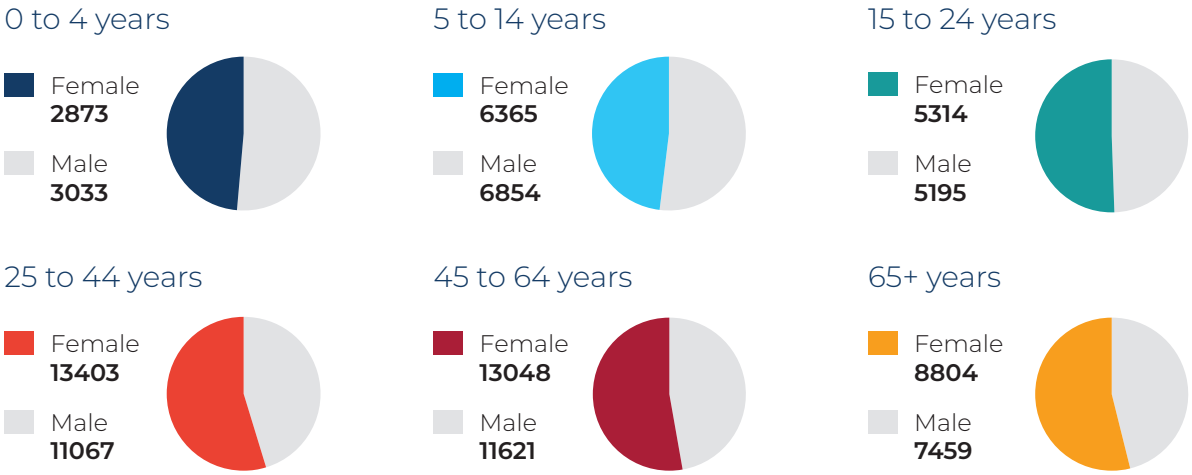
7.06% Quintile 4 population [1]

2.09% Quintile 5 population [1]

Age Group Profile

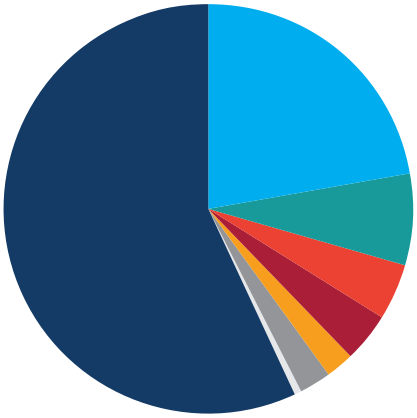


Age Group by Gender



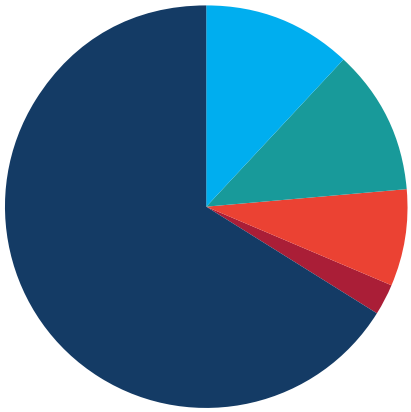
[1] Deprivation is reported in 'quintiles'.
Quintile 1 represents the least deprived section of the population while quintile 5 represents the most deprived section.

Ethnicity Profile



European	**57%** | **54201**
Chinese	**22%** | **21205**
Other Asian	**07%** | **6956**
Māori	**04%** | **3965**
Indian	**04%** | **3819**
MELAA	**03%** | **2282**
Pacific	**02%** | **2231**
Other	**01%** | **377**

Asian Ethnicity Breakdown



Chinese	**66%** | **21205**
Indian	**12%** | **3819**
Other Asian	**12%** | **3733**
South East Asian	**08%** | **2430**
Asian (not further defined)	**02%** | **793**

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.

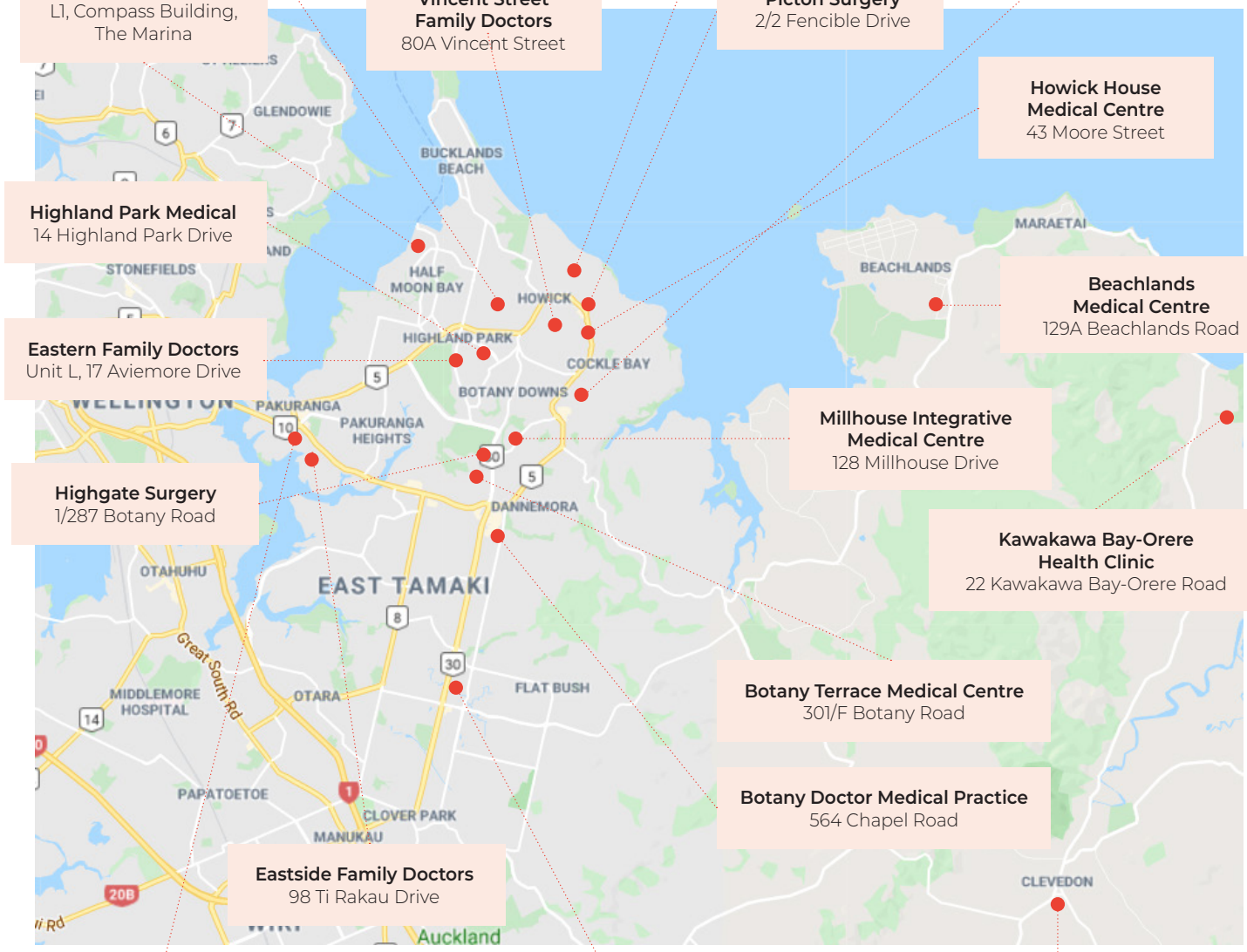
On arrival to New Zealand, refugees often have high health needs due to pre-migration experiences and this programme enables our general practice teams to provide tailored, culturally responsive health services for early intervention and improved access to essential services.

47 number of refugee patients

97 number of refugee consultations held

Our Practices

East Health Trust PHO represents 19 general practices in the East Auckland and Franklin area with 89 General Practitioners (GP) and 81 Practice Nurses.



Juliet Ave Surgery
59 Juliet Avenue

Crawford Medical Centre
4 Picton Street

Sommerville Surgery
E3 119 Meadowlands Drive

Marina Medical
L1, Compass Building, The Marina

Vincent Street Family Doctors
80A Vincent Street

Picton Surgery
2/2 Fencible Drive

Howick House Medical Centre
43 Moore Street

Highland Park Medical
14 Highland Park Drive

Beachlands Medical Centre
129A Beachlands Road

Eastern Family Doctors
Unit L, 17 Aviemore Drive

Millhouse Integrative Medical Centre
128 Millhouse Drive

Highgate Surgery
1/287 Botany Road

Kawakawa Bay-Orere Health Clinic
22 Kawakawa Bay-Orere Road

Botany Terrace Medical Centre
301/F Botany Road

Botany Doctor Medical Practice
564 Chapel Road

Eastside Family Doctors
98 Ti Rakau Drive

Pakuranga Medical Centre
11 Cortina Place

Botany Junction Medical
110 Michael Jones Drive

Clevedon Medical Centre
27 Papakura-Clevedon Road

87 General Practitioners

64 Full-time equivalent General Practitioners

1,485 GP to Patient Ratio

80 Practice Nurses

52 Full-time equivalent Practice Nurses

1,808 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

Cornerstone Accreditation

Aiming for Excellence is a quality improvement standard for general practices. It sets out best practice criteria to achieve over and above the minimum legal, professional and regulatory requirements. Practices are supported through the accreditation process.

100% East Health practices have achieved Cornerstone 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

TRUSTEE

	Portfolios	Area of Focus
Dr Brett Hyland (Chair) *Chair from April 2020*	Operational Finance Strategy	MSO and Contract Reviews
David Bryant	Community Liaison Finance	Community Engagement
Dr Denis Lee *(Resigned as chair and member from the Board of Trustees in April 2020)*	Operational Finance Organisational Relationships Clinical Governance Clinical Programmes Strategy	CCM and Care Plus MSO and Contract Reviews PHO Alliance, CMH
Dr John Betteridge	Organisational Relationships Operational	GPNZ
Kitty Chiu	Community Liaison Asian Population Strategy Operational	Programme Delivery
Dr Richard Coleman	Clinical Governance Clinical Programmes Finance	Clinical Advisory Committee
Stephanie Vance	Clinical Governance Clinical Programmes Organisational Relationships	Nursing GPNZ

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
- **David Harrison**
  Nursing Director, East Health Trust
- **Dr Denis Lee**
  General Practitioner, Pakuranga Medical Centre
  (Resigned as chair and member of the Clinical Advisory Committee in April 2020)
- **Dr Eileen Sables**
  General Practitioner, Pakuranga Medical Centre
- **Jocelyn Meynell**
  Nurse Practitioner, Highland Park 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 Practice
- **Dr Richard Coleman**
  Trustee, East Health Trust and; General Practitioner, Millhouse Integrative Medical Centre
- **Dr Simon Russell**
  General Practitioner, Pakuranga Medical Centre

Community Advisory Committee

East Health's Community Advisory Committee responds to and provides advice to the board on community perspective of health, planning and implementation in respect to community initiatives and 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
- **Jenny Carter**
  Chief Executive Officer, Beachlands Community 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
- **Zhengxiu Xie**
  Information Consultant, Independent Living Service Charitable Trust

COVID-19 Response

When COVID-19 emerged as a global pandemic, East Health Trust rapidly became pivotal in supporting the follow up testing of the 3rd new case to reach New Zealand in February 2020 from a flight from the Middle East affecting a family living in Flatbush. Auckland Regional Public Health approached the PHO nursing team directly to arrange to swab other symptomatic members of the household who later returned additional positive COVID-19 tests.

Our Nursing team were already fully conversant with infection, prevention and control principles including safe use of Personal Protective Equipment (PPE) enabling the team to be first responders to test this family.

Community Based Assessment Centre (CBAC)

From 28 March 2020, New Zealand went into national lockdown at alert level 4, the PHO rapidly mobilised a community testing team at the Community Based Assessment Centre (CBAC). The team remained heavily committed to fulfilling the role of Operational Lead within Spectrum House CBAC on Botany Road. This 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.

From June – July 2020 we ran CBAC extended support to the regional mobile teams operating across the managed isolation hotels seven days a week. With a depleted workforce this became challenging to manage high volumes of additional COVID-19 swabbing activity with a need to continue to provide a team at Spectrum House Botany Road through to the end of July 2020.

With an ongoing requirement to swiftly respond to new cases and clusters across Auckland, mobile “pop up” surveillance and testing continued. PHO staff and admin have continued to support redeployment to help undertake further community testing.

The team at the
Botany Road Community
Based Assessment Centre site

Strengthening General Practice

Over recent years we have been working with our Practice personnel to assist them to become more patient centric, part of this focus is to look at different strategies to deliver patient care. During the early stages of the COVID pandemic these new strategies were quickly expanded upon. The majority of patients have access to patient portal information among other things allowing patients to order repeat prescriptions without leaving their homes. Practices started providing virtual consultations either by video or phone and many initiated triaging services to ensure patients and care providers optimise their valuable time without the increased risk of infection.

In the early stages of lockdown, East Health personnel provided daily Zoom meetings to practices and to East Health personnel working from home. This ensured everyone was kept up-to-date of the latest information being provided by the different health agencies.

Also at this time, we established a COVID swabbing clinic, this clinic was recognised by Counties DHB as being one of the most efficient in the area., more than once we were able to establish and man a clinic with as little as 12 hours notice.

Historically CME / CNE events have been held on premise, these are now available virtually. East Health is now recording the majority of these events, the recordings are held securely on the East Health Extranet and are available for practice personnel to watch at a time of their choosing.

6,540

COVID-19 tests conducted at our pop-up community testing centre

A Year in General Practice

95,036

East Health Trust Total Population

304,602

Number of Consultations by GPs and Nurses

898

Number of **Babies Born**

2,869

Babies immunised out of 2,971

23,993

Cervical Screening tests completed for women aged 25-69

11,617

Breast Screening tests completed for women aged 45-69

4,175

Patients supported through **Cognitive Behavioural Therapy (CBT)**

4,189

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

11,327

Care Plus for Complex Health Needs patient visits

558

Smokers Quit

142

Patients attended **Self Management Education**

278

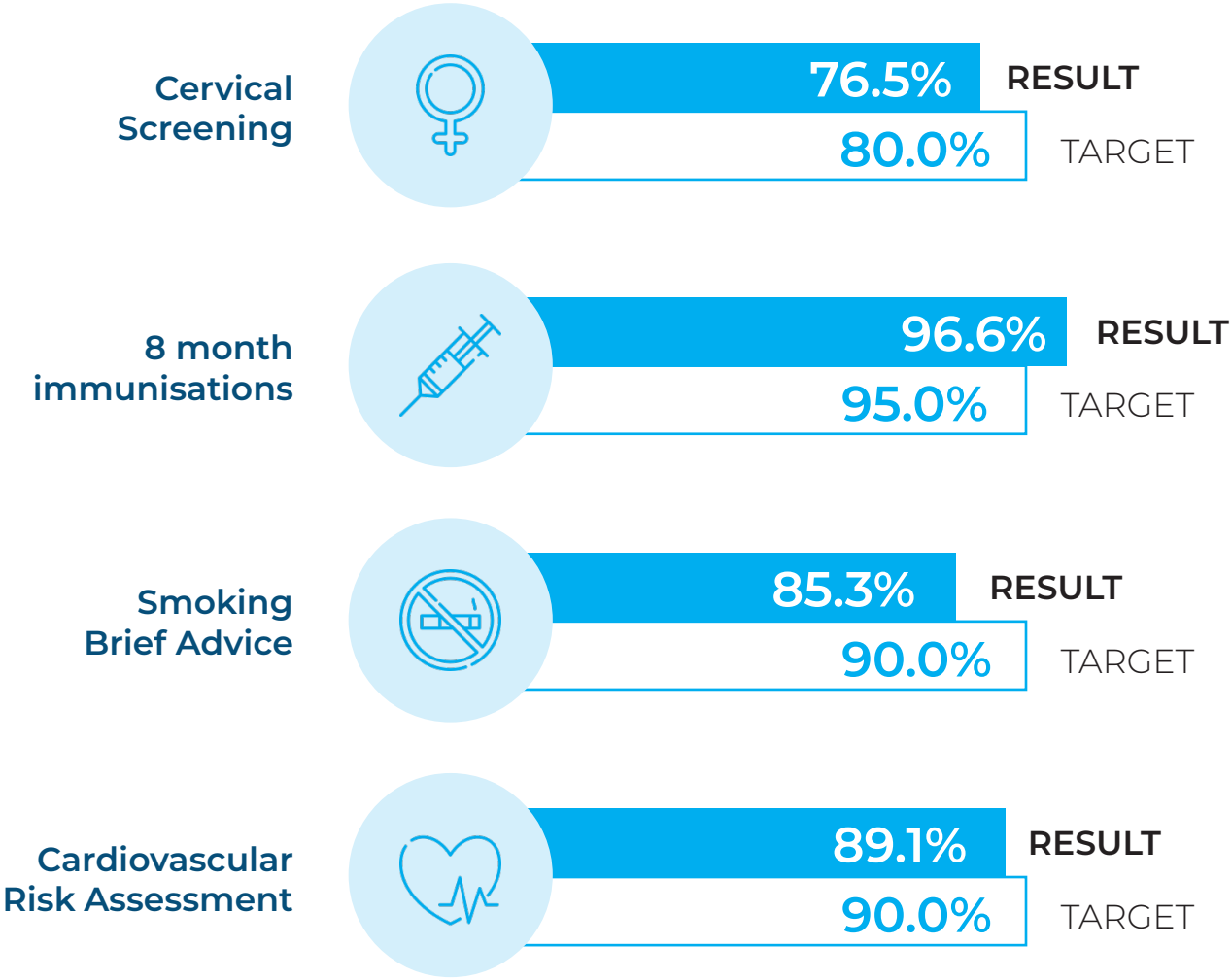
Referrals to **Green Prescription** Health and Wellbeing Programme

Health Target Performance

The East Health Quality Framework for 2019-2020 contained a mix of national health targets, Metro Auckland clinical indicators and System Level Measures (SLMs). Funds allocated to SLMs were paid in full to the practices during Covid-19 alert levels 4 and 3.

Other notable results include:

- Smoking prevalence rate for our enrolled population is 7.3%.
- 558 people quit smoking in the past year (11.8% of our smokers).
- 44.2% children aged 0-4 years eligible for influenza vaccine due to being hospitalised with a respiratory condition were vaccinated this year compared to 25.2% the previous year. For Māori children the increase was from 9.4% last year to 29.5% this year. For Pacific it was 8% and 36.8% respectively.
- In pregnant women, pertussis vaccination has risen from about 20% in 2016 to 59% in 2020 and influenza vaccination from about 27% in 2017 to 48% in 2020.



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 through the year at our premises and/or virtually via zoom.

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

51 number of educational sessions and workshops delivered

969 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 pop function 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 Practicing 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 (CMH) Nursing Professional Development Programme (PDRP). This programme requires nurses 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 CMH evidence guidelines in collaboration with Counties Manukau DHB. Currently there are 44 nurses employed across PHO practices actively engaged in the PDRP programme.

The benefit of providing this programme is that it enables East Health to provide support and professional leadership to nurses, as well as a means to evaluate the level of practice within primary health nursing. The benefit to nurses of being part of a district wide approach is to create a seamless transition between Primary and Secondary healthcare nursing, as well as providing support and evaluation of skill and competency for primary care nursing to improve timely access for patients to receive high quality care as well as meeting legislative Nursing Council requirements.

Nursing Education Fund

East Health's Scholarship education fund supports the Nurse Practitioners, Registered Nurses and Enrolled Nurses employed in our 19 clinics across 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 HWNZ funding to support professional development of the nursing workforce the PHOs Education fund this year has supported:

- Post graduate University papers to attain Registered Nurse Prescriber qualification
- Asthma 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 deliver 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.

Physiotherapy Services

Otago Exercise Programme (OEP) for Falls Prevention

This programme is for people 75 years and over (65+ Māori and Pacific people) who have had a fall in the last 12 months.

200 number of participants to OEP

The majority of patients made a considerable improvement to their strength and balance, lessening the likelihood of having another fall.

Screening for falls has become routine in general practice as part of the 'Live Stronger for Longer' programme which has contributed to the growing referral rate.

Patients referred who did not meet the criteria were referred on to Group Fitness Classes in the community to support their health needs.

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 home and a suitable exercise programme 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.

Osteoarthritis Programme

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

33 number of participants to the Osteoarthritis programme

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.

Hydrotherapy Pool Classes

Patients referred to this course are eligible with a diagnosis 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 Prescribing

542 number of medication reviews conducted

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

Patient Story

As the Clinical Advisory Pharmacist for East Health Trust PHO, I receive referrals from practices to provide medication reviews for patients. Medication reviews can differ in complexity; from introduction of simple measures to support correct use of medicines every day, to a comprehensive clinical review that requires multidisciplinary input and a number of follow-up contacts.

The Integrated Care Coordinator (ICC) and I were contacted by a practice nurse with concerns about a 94 year-old gentleman with cognitive impairment and uncontrolled hypertension due to the erratic way he took his medicines. The practice had just prescribed a blister pack to help him manage.

During the visit, he was noted to be confused with how his newly delivered blister packs worked and was unable to recall what, when or if any medications had been taken. The ICC was able to check his Blood Pressure (BP) immediately for hypotension and any immediate signs of overdose. His BP was normal.

To prevent a potential overdose, I removed his extra medications with his consent. I left only his blister packs on the dining table next to his newspaper that he reads over breakfast every morning. I reiterated how to take medicines out of the blister pack and suggested he check the newspaper date as a reference.

On our follow-up visit, his BP remained normal and he had taken medicines out from the blister pack in the correct date order. Suggestions were made to his doctor to consider a less stringent BP control, rationalise the three BP medications and simplify the regimen to once daily because of his improved compliance. By working collaboratively with the practice, community pharmacy and the Community Geriatric Services we can ensure he is safe and supported, and can continue to achieve his goal to live independently in his own home.

Diabetes and Long Term Conditions Management

Supporting People with Diabetes

The apps in our data visualisation tool, Qlik Sense, have been improved to provide practice information to support key diabetes indicators. These NHI level reports allow GPs and nurses to view their care of all their people with diabetes at a whole practice level. They are integral to support the start-up of nurse-led diabetes clinics and also allow practices and individual GPs to monitor their own progress.

8,185 **Diabetic Patients**

95,036 TOTAL POPULATION

CVD Risk Assessment and Management

This years' highlight has been the October implementation of the updated (2018) cardiovascular risk assessment algorithms which predict CVD risk based on the New Zealand population. The key change EHT implemented were the starting ages for assessment, 5 years earlier for our Māori, Pacific and South Asian populations.

4,414 **CVD Patients**

95,036 TOTAL POPULATION

CVD Secondary Prevention

Primary prevention of CVD is the treatment of high risk patients with dual therapy (blood pressure lowering, statins at minimum) to prevent a first CVD event such as a stroke or MI. The introduction and use of the 2018 CVD algorithms reduced CVD risk scores and changed management advice thresholds. The focus this year was to ensure that the risk assessments for high risk people were as accurate as possible.

771 **Patients Eligible for Primary Prevention**

95,036 TOTAL POPULATION

CVD Secondary Prevention

An audit for use of triple therapy (blood pressure lowering, statins and aspirin) for the secondary prevention of CVD was presented to GPs in November. The ability to exempt patients from treatment should they decline, be contraindicated or intolerant to the drugs was also implemented. Recording exemptions in the PMS and subsequently in the Qlik app allows further specificity for future audits. NHI level patient information supports practices and the PHO for both patient care and monitoring improvement.

3,861 **Patients Eligible for Primary Prevention**

95,036 TOTAL POPULATION

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 health care 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 hospital, and in 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 were held monthly 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 health care 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

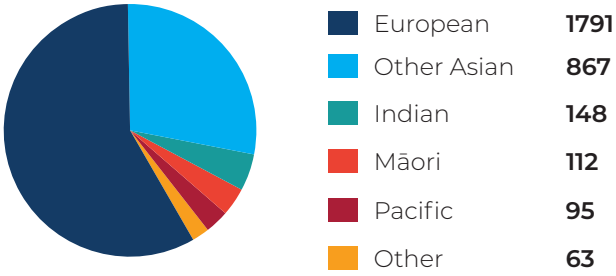
Counties Manukau District Health Board (CMDHB) have adopted equity targeting in their approach to supporting people with long term conditions with their focus on diabetes and improving health outcomes for Māori, Pacific, CSC holders and people living in quintile 5.

Due to many of our patient population not meeting CMDHBs criteria for services and 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 make provision of a comprehensive package of primary health care services at a reduced cost for those people who could be identified as having higher health needs.

3076 Patients enrolled in the Care Plus programme

Care Plus patients by ethnicity



Nurse Led Clinics

Nurse-led clinics provide expert nursing care to people experiencing a range of health issues, working collaboratively with the interdisciplinary team where indicated. There is increasing evidence demonstrating improved health outcomes, cost effectiveness, and quality of life for people attending nurse-led clinics. There is a multitude of examples demonstrating the benefit of nurse led care to improved patient outcome and clinical efficiencies operationally and fiscally.

East Health Trust PHO have a number of blended nurse led clinics with a total of 11nurse led clinics for paediatric care, CVD and diabetes support, travel medicines and Nurse Practitioners, designated nurse prescribers and community nurse prescribers providing nurse led care for both the management of common ailments as well as long-term condition patients to include full assessment, diagnosis, prescribing and ongoing long-term condition management.

East Health Trust PHO support 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.

Multidisciplinary Team (MDT)

A number of East Health Trust PHO practices have adopted an integrated team approach to evaluating treatment options and healthcare planning for their patients, those often with acute or chronic disease conditions and multiple health problems.

The team involves medical, specialist and allied healthcare professionals meeting regularly, in the practice where patients can be involved in their health care decisions.

This team approach supports improved health outcomes for patients and reduces hospital admissions, re-admissions and length of hospital stays.

Patient Portals

Patient portals are a secure and convenient online tool helping patients interact and communicate with their healthcare providers and helping providers streamline how they interact with patients.

A big focus for a number of practices is to assist patients to use more services via their patient portals such as booking appointments online and ordering repeat

86% percentage of East Health patients who have access to portals

Bi-Annual PHO Symposium

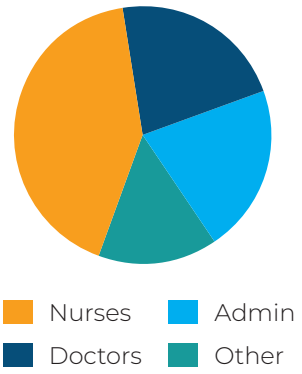
We held our third bi-annual PHO symposium on Saturday 14 September locally at the Waipuna Hotel and Conference Centre.

The Symposium is targeted to the PHO's practice teams (GPs, Practice Nurses and administration staff) who provide health care to our total enrolled population of 95,036 patients.

This Symposium bought a range of speakers from primary and secondary Care to deliver practical and informative workshops. It is also a fantastic opportunity for networking among peers to connect and share ideas and experiences.

Feedback from speakers highlighted a positive experience and they found engagement with primary care to be essential and a positive bridge to future experiences for patients.

117 Attendees



Planned Proactive Care Programme Evaluation

East HealthTrust's Data analyst team worked with a research analyst with Massey University to complete a Multi-Criteria Evaluation of the Planned Proactive Care programme, comparing healthcare utilisation and outcomes for patients that were enrolled on Planned Proactive Care versus a control group.

People with long-term conditions is one of the biggest challenges facing in New Zealand's health system. These patients are responsible for a large proportion of healthcare spending and is associated with higher health service utilisation across a range of providers, including more hospital admissions and increased length of stay. Planned Proactive Care (PPC) proposed a plausible way in which to improve the management of these patients, improving their outcomes and experience, and, potentially, reducing hospital admissions.

The aim of this analysis was to compare the average number of Emergency department (ED), inpatient admissions (IP) and GP utilisation between patients in the PPC programme and patients in the control group.

Methodology

The project studied 94 participants in the intervention group and 307 in the control group. To determine the effects of the PPC programme on the use of healthcare resources, the analysis compared ED, IP and GP visits between intervention group and control groups over two years' time.

Multi-Criteria Decision-Analysis (MCDA) was used to capture stakeholders' prioritises and preferences for criteria. Weighted performance on each criterion is aggregated into an overall value score, which is then compared between the two.

Emergency Department Analysis

Table 2 shows a snapshot of the average number of Emergency Department (ED) admission between the PPC intervention group and the control group within first 2 years of completing the first PIH questionnaire. The result in table 2 showed that those in the PPC intervention (M=6.9, SD=3.6) had 1.5 fewer mean ED admission than the control group (M=8.4, SD=5.6).

Table 2	Control	Intervention
Average ED Admissions	8.4±5.6	6.9±3.6

At the start of the programme, intervention group had a higher average (0.85) of ED visits compared to the control group (0.64). However, after 1 year of the programme, intervention group performed better than the control group.

Average number of ED admission per person over the 2 years' time	Year 0	Year 1	Year 2	Total
Control	0.64	1.37	0.73	2.74
Intervention	0.85	0.71	0.69	2.25
T-test significance	0.8	0.3	0.3	

Outcome Mapping

Measures of performance of the programmes that were considered relevant to inform decision making. For each of the outcome, scores were obtained for the control and intervention group using the averages and logistic regression methods.

Outcomes	Control Group	Intervention Group
Physical functioning	5.6	6.1
Social relations & participation	6.2	6.7
Enjoyment of life	5.8	6.3
Resilience	5.6	6.2
Quality of care	7.2	7.4
Management of the condition(s)	6.6	7
Management of HbA1c	3.8	1
Management of BP	1	1
Cost of EDs	2.7 x $403.4 = $1089.18	2.3 x $403.4 = $927.82
Cost of IPs	5.3 x $4921.16 = $26,082.15	6.8 x $4921.16 = $33,463.89

Standardised Outcome Scores

Relative standardisation was used to transform and standardise the scores so that all the results are on the same scale.

Outcomes	Control Group	PPC Intervention
Physical functioning	0.68	0.74
Social relations &participation	0.68	0.71
Enjoyment of life	0.68	0.72
Resilience	0.67	0.74
Quality of care	0.70	0.72
Management of the condition(s)	0.69	0.73
Management of HbA1c	0.25	0.97
Management of BP	0.71	0.71
Cost of EDs	0.65	0.76
Cost of IPs	0.79	0.61
Cost of GP consultation(s)	0.67	0.74

Relative Weights

To obtain the relative weights for each outcome, a multi-stakeholder holder questionnaire was sent out to patients, professionals, payers and policy makers.

Outcomes	Patients	Professionals	Payers	Policy Makers
Physical functioning	9.5	9.5	8.7	9.5
Psychological Wellbeing	9.3	9.4	8.7	9.5
Social relationships and participation	8.9	8.5	8.7	7.7
Enjoyment of life	9.4	9.3	8.0	9.2
Resilience	9.3	8.9	9.0	9.5
Quality of care	9.0	9.0	8.7	8.7
Management of condition(s)	8.9	8.5	8.7	8.8
Costs (ED, IP, GP)	3.8	6.0	7.3	4.7

Overall Value Calculations

The standardised performance scores on each outcome are multiplied with the corresponding weights to calculate the partial value scores. These partial value scores are summed to obtain the overall value score for each of the alternatives and stakeholder groups in the MCDA table. the PPC intervention with the highest overall value is the preferred alternative.

	Patients		Professionals		Payers		Policy Makers	
Outcomes	**Controls**	**PPC**	**Controls**	**PPC**	**Controls**	**PPC**	**Controls**	**PPC**
Physical functioning	6.46	7.03	6.46	7.03	5.92	6.44	6.46	7.03
Social relations & participation	6.05	6.32	5.78	6.04	5.92	6.18	5.24	5.47
Enjoyment of life	6.39	6.77	6.32	6.70	5.44	6.62	6.26	6.62
Resilience	6.23	6.88	5.96	6.59	6.03	6.66	6.37	7.03
Quality of care	6.30	6.48	6.30	6.48	6.09	6.26	6.09	6.26
Management of the condition(s)	6.14	6.50	5.87	6.21	6.00	6.35	6.07	6.42
Management of HbA1c	2.23	8.63	2.13	8.25	2.18	8.44	2.20	8.54
Management of BP	6.32	6.32	6.04	6.04	6.18	6.18	6.25	6.25
Cost of EDs	2.27	2.89	3.90	4.56	4.75	5.55	3.06	3.57
Cost of IPs	3.00	2.32	4.74	3.66	5.77	2.87	3.71	2.87
Cost of GPs	2.55	2.81	4.02	4.44	4.89	5.40	3.15	3.48
Overall value score	53.94	62.95	57.52	66	59.17	66.95	54.86	63.54
Preferred alternative		**PPC**		**PPC**		**PPC**		**PPC**

Conclusion

The PPC intervention group scored a higher overall value than the control group for all the stakeholder groups: patients, professionals, payers, and policy makers. Differences were mainly caused by management of HbA1c and all the subjective indicators.

This suggests that the PPC programme improves care for people with long term conditions (LTC) delivering overall better health outcomes for patients, their families, and the wider healthcare system.

In conclusion, patients in the PPC intervention performed better than the control group when taking into consideration the health outcomes, the experience of care and the resources costs for patients with long-term health conditions. Also, PPC intervention is effective based on both clinical and social indicators. Lastly, it is proven that PPC programme can foster patient self-management and enhanced shared decision making with personalised care plans and shared goal setting agreement between general practitioners and the patient.

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 health care planning.

Our data platform is flexible and easily scalable, and this year we welcomed new vendor systems Evolution and Indici. These systems have been fully integrated into our warehouse, allowing for standardised reporting from primary care data, complemented by national and secondary datasets. This means that information regarding National Enrolment Service (NES), System Level Measures (SLM) and Health Targets can be reported easily and timely.

Business intelligence and data visualisation tool Qlik Sense is used to ensure all our practices have access to dashboards and reports through a secure connection. These dynamic reports allow frontline staff to get up-to-date clinical and patient demographic information to make informed decisions for better and equitable health outcomes.

Principals and managers have access to information to support proactive patient care planning, resourcing and strategic initiatives. Financial reports facilitate NES exception remediation and provide monthly capitation details.

Reporting assists our practitioners with:

- Support for patients with Diabetes and Cardiovascular Disease
- Monitoring Flu vaccination uptake by patients 65 years and older
- Anticoagulant medication review for patients with Atrial Fibrillation (stroke prevention)
- 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 practices.

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 DHB and Ministry of Health.

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.

164 attendees to Self Management Education

15 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.

LIVEWELL Weight SME

A 6-week programme, led by a registered dietitian, is for people wanting to live a healthier lifestyle. The programme covers topics such as; nutrition, eating behaviour, physical activity and goal setting to encourage people to make lifestyle changes.

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.

Healthy Eating Workshops

This 3-hour workshop is for patients to be able to participate in a meal demonstration, watching step by step how food is prepared, cooked and learning new tips about healthy eating from a registered nutritionist.

Health Promotion Activity

School, Teacher and Counsellor Engagement

Our Health Promotion Coordinator connects made contact/connection with schools in our locality in relation to exploring ways to develop school based resilience with our youth.

Facilitated training for a Senior Leadership team was conducted at a local primary school, mindfulness meditation drop-in support session for teachers and supported a youth provider's focus group held for young people to discuss what services they would like to see in the community.

Connections continue to thrive in this space and is an important area of focus for us to engage with our local schools.

Presentations in the Community

- Participated in Kawakawa Bay's Wellness Day (August 2019). Our fat and sugar kit drew quite a crowd and our Health Promotion Coordinator presented a one-hour workshop on the Science of Mindfulness.
- Presented to a crowd of 40+ at the Parkinson's support group on ways to reduce stress.
- Continue to support the Green Prescription community programme, speaking each term on being Mindful and providing stress reduction techniques/tips.
- Presentation at Howick Library on the Science of Mindfulness (March 2020) with over 30 people in attendance.
- Nourishing our relationship with Howick Marae in supporting Matariki celebrations July 2019, the Health Promoter also delivered a workshop on stress reduction techniques In October and met with the community gardening volunteers and contribution to a wellness morning which our local communities attended.

Community Walk Event

A successful community walk took place on 6 November 2019 with around 100 people participating. Our Health Promotion Coordinator worked with Sport Auckland and St Paul's Church in Flat Bush to organise the event. Walkers met at St Paul's in the park church and were guided around the track with some people walked the 2.5km around the park, and others walking the same route twice (5km). The walk was also supported by St Johns' paramedics.

The walk was followed by a healthy morning tea, with quick fire presentations from East Health Trust, Sport Auckland and Living Streets Aotearoa. Auckland Libraries spoke about their coffee mornings. A walking group was established following this event, meeting weekly to reduce social isolation and connect communities, stay healthy and make new friends.

Financial Summary

Statement of Comprehensive Revenue and Expenses

	Note	2020	2019
Revenue			
Revenue from Non-Exchange Transactions			
Provider Funding		17,465,774	16,686,902
Health Projects		5,725,129	4,982,942
Management Fees		684,249	689,219
Total Revenue		23,875,152	22,359,063
Direct Costs of Services			
Provider Funding		(17,465,774)	(16,687,991)
Health Projects		(5,982,021)	(4,581,246)
Management Fees		(561,084)	(565,177)
Total Direct Costs of Services		(24,008,879)	(21,834,414)
Gross Surplus		(133,727)	524,649
Expenses	3a	(317,375)	(301,383)
Operating Surplus / (Deficit)		(451,102)	223,266
Finance Income	4	87,749	107,061
Net Finance Income		87,749	107,061
Share of profit of associates	5	70,191	80,035
Total Surplus / (Deficit) for the year		(293,162)	410,362
Total Comprehensive Revenue and Expense for the year		**($293,162)**	**$410,362**

Statement of Financial Position

	Note	2020	2019
Assets			
Current Assets			
Cash and Cash Equivalents		427,554	239,162
Short Term Deposits		2,566,796	3,048,488
Trade and Other Receivables from non-exchange transactions		276,232	157,617
		3,270,582	3,445,267
Non Current Assets			
Investment in Associates	5	636,008	577,817
		636,008	577,817
Total Assets		3,906,590	4,023,084
Liabilities			
Current Liabilities			
Trade and Other Payables from non-exchange transactions		168,225	159,428
Payables to related parties	8	485,718	317,847
Accruals		9,500	9,500
		663,443	486,775
Total Liabilities		663,443	486,775
Net Assets		**$3,243,147**	**$3,536,309**
Equity			
Corpus		10	10
Retained Earnings		3,243,137	3,536,299
Total Equity		**$3,243,147**	**$3,536,309**

Statement of Changes in Net Assests/Equity

	Note	Corpus	Retained Earnings	Total Equity
As at 1 July 2018		10	3,125,937	3,125,947
Surplus for the year		-	$410,362	$410,362
Total comprehensive Revenue and Expense for the year		-	$410,362	$410,362
Balance at 30 June 2019		**$10**	**$3,536,299**	**$3,536,309**
Deficit for the year		-	(293,162)	(293,162)
Total comprehensive Revenue and Expense for the year		-	(293,162)	(293,162)
Balance at 30 June 2020		**$10**	**$3,243,137**	**$3,243,147**

Statement of Cash Flows

	Note	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash was received from:			
Customers		23,751,364	22,514,773
Interest		93,931	108,400
Goods & Services Tax		-	15,807
		23,845,295	22,638,980
Cash was applied to:			
Suppliers & Employees		24,149,586	22,269,563
Goods & Services Tax		1,009	-
		24,150,595	22,269,563
Net cash received from / (applied to) operating activities		**(305,300)**	**369,417**
CASH FLOWS FROM INVESTING ACTIVITIES			
Cash was received from			
Dividends from associates	5	12,000	12,000
Proceeds from termination of term deposits		481,692	-
		493,692	12,000
Cash was applied to:			
Investments in term deposits		-	683,726
		-	683,726
Net cash from / (applied to) investing activities		**493,692**	**(671,726)**
Net cash received (paid) for the year		**188,392**	**(302,309)**
Cash and cash equivalent balance at 1 July		**239,162**	**541,471**
Cash and cash equivalent balance at 30 June		**$427,554**	**$239,162**

Statement of Cash Flows

Reconcilitation of Net Surplus to Cash Flows from Operating Activities

Reported Surplus / (Deficit) for the year		(293,162)	410,362
Non-cash items: - Share of loss (profit) of associates	5	(70,191)	(80,035)
		(363,353)	330,327
Movements in working capital items:			
Accounts Receivable		(117,606)	157,049
Accounts Payable		176,668	(133,766)
Net GST		(1,009)	15,807
		58,053	39,090
Net cash received from operating activities		**($305,300)**	**$369,417**

East Health Trust PHO
Annual Report 2020

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