



**Annual Report  
2007**



[www.harbourhealth.org.nz](http://www.harbourhealth.org.nz)



## OVERVIEW

---

Chair of the Board Report.....	5
Chief Executive Report.....	6
Harbour Health and its Community.....	7

## ACHIEVEMENTS AND PERFORMANCE

---

Active Families .....	11
Asian Smokefree Communities .....	13
Care Plus.....	15
Cardiovascular Disease and Diabetes Risk Assessment .....	16
Diabetes .....	17
Dietitian .....	20
Health Awareness Days .....	23
Immunisation and Outreach Immunisation Service .....	24
North Shore Lifestyle Project.....	25
Otago Exercise Programme .....	26
Pharmacy Facilitator.....	28
Primary Care Nursing Professional Development .....	30
Primary Options.....	32
Push Play Neighbourhood – Warkworth/Mahurangi East.....	33
Respiratory .....	34
Retinal Eye Screening.....	37
Services to Improve Access .....	38

## FINANCIALS

---

To Be Provided Under Separate Cover

## OUR STRUCTURE

---

Organisation Chart .....	42
Board Members .....	43
Membership.....	44
Contact .....	45



## Overview

## Overview

### Chair of the Board Report

---



Harbour Health has now been in existence for over two years and has undergone a change in name as you can see. The seventh member of the Board, representing the primary care team, was elected during the course of the year and is Dr Warren Groarke. The other six Board members are Paddy Sullivan (appointed by Rodney Health Link), Carol Ryan (appointed by the North Shore Community Health Voice), Jane Retimana (Iwi representative, Ngati Whatua), Dr Helen MacDonald (CHS representative), Dr John Arcus (CHS shareholder representative), and myself.

Some of Harbour Health's profound successes have been the Asian Smokefree Communities project, which not only won an Innovations Award but also has now received Waitemata District Health Board funding for a district rollout. The Primary Options Project will hopefully be run under the auspices of Harbour Health within the near future. Other projects currently run by the PHO include Care Plus, Health Promotion, the Otago Exercise Programme, Diabetes, Primary Lifestyle Options, Pandemic Planning, Respiratory project, PMP, Immunisation, Retinal Screening, SIA projects and Transfer of Care.

Care Plus is still struggling to be self-sustaining because of the District Health Board's mode of funding, which is retrospective. Consequently lower levels of funding only are available until certain thresholds of use are achieved. Then the funding increases which means it is always operating at a deficit. With greater uptake by the practices it is hoped that the next level of funding will be attained and thus bring Care Plus to a sustainable position.

Our Chief Executive continues to represent the interests of Comprehensive Health Services members through the PHO in the contract negotiations at PSAAP. She also is a member of the PSAAP Facilitators group that acts rather like an executive forum and provides valuable insight to the negotiations. Having said that, the structure and function of PSAAP itself is to be redefined within the next few months. The PHO contract is also under review and our Chief Executive is intimately involved with this as well.

Our research into population health needs continued to develop and expand with Symphy Tindi's work into communities of interest and the development of Memorandum of

Understandings with Non Government Organisations and community groups. Jill Calveley, Clinical Director, has been responsible for the collation of health data in our enrolled population and we are now in the enviable position of being the only PHO with comprehensive health information. From this information it will be possible to identify the areas of need and so take forward the concepts of the Primary Health Care Strategy – to reduce inequalities in health, and improve the overall health outcomes in our communities.

As you are all aware Harbour Health was the Intervener in the recent dispute between LabTests and Diganostic Medlab Limited (DML), and the Auckland District Health Boards. The High Court found in favour of the Intervener in that PHOs and providers were not adequately consulted prior to the decision to contract for laboratory services. Because of the Judges ruling, community consultation has become more than it ever was, and we are not yet exposed to the full consequences I am sure. LabTests is appealing the Courts decision but an interim contract has been awarded to DML pending further consultation, result of the appeal and subsequent tendering processes. Harbour Health, in its role as Intervener, is still involved as there has not yet been any consultation regarding the new contract.

Harbour Health is highly regarded in the health sector as being a harbinger of change, both disruptive and innovative, challenging and discomfiting for some. The next 12 months will continue to see Harbour Health at the forefront of developments in the field of Primary Health Care.

Kate Baddock  
Chair





It is with great pleasure that I present Harbour Health's Annual Report for the 2006/2007 financial year. As I have read the contents of this report it amazes me the extent of achievements of Harbour Health through our staff and providers in only our second year of operating. During these last 12 months we have:

- Developed and made progress on our strategic plan;
- Consolidated the operations of Harbour Health;
- Implemented new services;
- Achieved national recognition for innovation; and
- Lead a community response to the Auckland Region's Laboratory contract.

Harbour Health has been focused on the development of a strategic plan and the consolidation of our infrastructure and operations. In the last year we have reorganized our structure to ensure more effective alignment with our strategic plan. This change has sought to develop more effective relationships with General Practice and community, as well as a focus on programme and operations management.

Harbour Health's strategic plan has led to the development of a population health approach, community engagement and the future development of service capability. This is to ensure that we understand the needs of the community and work with them to develop appropriate solutions. We also want to further ensure that there is the capability within a community to deliver the services to meet these needs we have identified. This year the focus has been on General Practice to ensure ongoing sustainability of this sector. Harbour Health anticipates that it will be in a position to influence needs based contracting within the next two years. At present many new services are as a result of national or district health board initiatives.

In response to identified local need and national/district wide need new services were initiated such as ASC Smoking Cessation, Push Play Neighbourhood Programme in North Rodney and the expansion of the ACC Falls Programme. In addition we have been involved in the development of new services for mental health and Cardiovascular Disease and Diabetes. Harbour Health has

also secured additional funding for the expansion of Primary Options, discharge planning and development for the management of outpatient care within a primary care setting.

Harbour Health also entered the ASC Smokefree Programme into the Waitemata District Health Board Innovations Awards and won this award. This programme was also selected as a finalist in the National Innovations Award and was the only service to have received "Highly Commended Award" in any of the categories of these awards. I would like to congratulate the Harbour Health Staff involved in the design, development and implementation of this service. There has been an enormous amount of work and in particular involving other agencies and the Asian community in this initiative.

The most significant issue this year has been the Auckland District Health Board's decision to award the laboratory contract to Labtests. Harbour Health was extremely concerned about this change in contract in terms of appropriate consultation, GP capacity and patient safety. This concern resulted in the judicial review. The significant decision by the High Court required the DHB's to undertake an appropriate consultation process and has also set a precedence on the role of Primary Health Organisations in the Health sector. Harbour Health has been extremely proud to have been part of this landmark decision.

I anticipate that in the 07/08 financial year, there will be a significant impact of the Harbour Health vision and services for the community, providers and patients.

I look forward to my next year's report which will show our leadership, innovation and our excellent results.

Susan Turner  
Chief Executive



# Overview

## Harbour Health and its Community



### Demography

This report will describe the demography of the population enrolled with Harbour Health and compare it with that of the relevant Waitemata District population and New Zealand in terms of Geographical location and population distribution.

- Socio - Economic Status (SES)
- Ethnicity and migration trends
- Age and gender

Data Sources:

- Quarterly Primary Health data from practices affiliated to Harbour Health
- Census data from statistics New Zealand
- North Shore City Council
- Rodney District Council
- Existing community groups within the region

### Background

Harbour Health is one of six Primary Health Organisations (PHOs) located in Waitemata District Health Board (WDHB), one of three DHBs in the greater Auckland region. Waitemata DHB encompasses North Shore City, Rodney District and Waitakere City with a total population of 493,200 (2005 census), ie 36.9% of the total Auckland population; and 3.69% of the total New Zealand Population.

### Geography

Harbour Health is located in the North Harbour region of North Shore City, which is in the northern part of Auckland region. It serves a populations living in both rural and urban locations, ie Rodney District and North Shore City respectively.

### Population Trends

Continued migration into New Zealand has resulted in a general increase in population with the main increase being felt in regions close to Auckland City, including North Shore City and Rodney District

At a regional level the population has been increasing steadily since 2001. The population had risen in North Shore City from 194,200 in 2001 to 212,200 in 2005, a 9.3% rise and in Rodney an increase from 78,500 in 2001 to 89,200 in 2005 a 13.6% rise. . Migration has also resulted in a wide range of cultures and rapidly changing, incidence and prevalence of

disease requiring diverse approaches to planning and health service provision.

### Rodney District

Rodney District is the largest of the seven districts in the Auckland region and has the fifth largest and most widely distributed population due to its large geographical size. Rodney District is unique amongst rural districts because of its close proximity to Auckland City. Rodney District is one of the fastest growing districts in New Zealand after Queenstown and Tauranga.

Rodney district has a high adult population with 14.9% of the population 65 years and over, compared to 12.1% for New Zealand. 22.7% of the population is below 15 years.

### North Shore City

North Shore City is the fourth largest city in New Zealand (after Auckland, Hamilton and Christchurch). It is largely urban with a large industrial area, with the majority of the population concentrated around the old business regions. North Shore City also has a high adult population with a significant population between the ages of 25 – 44 years (83, 247) and a significant population 65 years and above (20,172)

### Harbour Health Enrolled Population

Harbour Health has the largest enrolled population among the six PHOs in the WDHB district, with a total enrolled population of approximately 147,000 (October 2007).

### Gender

The majority of patients enrolled with Harbour Health are from Rodney District and North Shore City, however, a small percentage are from other districts and regions. 44% of the enrolled population is male and 56% female.

### Ethnicities

The population enrolled with Harbour Health is multicultural; with over 116 ethnicities which are coded into six main groups: Maori, Pacific Island, European, Asian, Other and those with no stated ethnicity.

The Maori population enrolled with Harbour Health is 2.7% compared with 7.2% of Maori living within Rodney District, 6.5% in North Shore City and 14.1% for the whole of New Zealand.



## Overview

### Harbour Health and its Community

The Pacific Island population enrolled with Harbour Health is small compared to that of its population found in other parts of New Zealand. Only 1.4% of the Pacific Island community are enrolled with Harbour Health which is a reflection of the small Pacific Island population found within relevant Waitemata regions, ie 1.3% living in Rodney District and 3.2% in North Shore City, compared to 6.2% for the whole of New Zealand.

The largest ethnic group enrolled with Harbour Health is European (75.7%) reflecting that of North Shore City (73.3%), Rodney District (84.5%) and New Zealand (76.8%).

The enrolled Asian population is 9.4%: North Shore City (12.3%), Rodney District (2.14%) compared with 6.4% for the whole of New Zealand.

#### Socio - Economic Status (SES)

Despite the fact that North Shore City and Rodney District are known to serve a population in the higher social and economic groups, there is a significant population in the lower SES.

81.52% of the population accessing Harbour Health services are living in areas classified as deprivation levels 1, 2 and 3 (higher SES): A significant number of people (13,225 people or 8.96%) are living in areas classified as deprivation levels 4 and 5 or low SES).

The majority of those in deprivation levels are Maori, Pacific Island and new migrants (including refugees). This is consistent with national findings that also identify Maori, Pacific Island and New Migrants (especially refugees) as those with the highest representation in the lower socio -economic groups.

#### **Health Needs Analysis**

A Health Needs Analysis is being undertaken to gain knowledge of the health issues facing the population enrolled with Harbour Health, so that any services that are developed are increasingly effective at reducing health related inequalities and improving the health of the whole community.

#### **Background**

Understanding the health of a community is not easy. No country or organisation has 'the answer' regarding the best way to do this. Every service provider and community group has some of the answers, but always from their unique perspective. Interpretations of

what the words 'health' and 'disease' mean varies significantly across cultures as well as opinions about how to stay well.

Although still far from perfect, well designed research has made significant progress in discovering more effective ways of reducing our risk of becoming ill and of managing chronic conditions. However, there are still significant gaps in knowledge about how to make the most of this knowledge - especially when changing individual and community lifestyle habits.

We do not live in isolation. Role models and messages constantly received from our immediate families, whanau and society (e.g work, school, sports and media heroes, TV, advertising) have an enormous influence on behaviours, that can influence health outcomes - for better or worse.

In order to increasingly understand and work closely with its community in the North Shore and Rodney areas, Harbour Health has developed the following three stage process culminating in an annual plan. Each of these processes will give different information regarding actual health needs.

At Harbour Health, we are endeavoring to become increasingly skilled at linking all of this information to create a useful picture of the actual health needs of our communities. This will allow us to shape the way primary health care delivers its services and how it works closely with specialist and community services.

#### **Stage one: National Health and Demographic Analysis.**

Demographic analysis of North Shore and Rodney districts from the 2006 National census and Ministry of Health statistics give us background information about how our enrolled population compares with New Zealand statistics regarding the major causes of death, hospitalisation rates and prevalence of serious health conditions.

#### **Stage two: Health service utilisation analysis.**

Statistical analysis of how often our enrolled population uses health services will give us an indication of where access may be a major problem and also how different patterns of utilisation by age group, ethnicity or location is positively or negatively associated with overall health outcomes.

# Overview

## Harbour Health and its Community

---



### Stage three: Community engagement.

A new direction was formalised by the publication of the New Zealand Primary Healthcare Strategy (2001) which states that Primary Health Organisations (PHOs) are required to 'Work with local communities and enrolled populations by organising services around defined populations – rather than just responding to those individuals who actively seek care. Primary Health Care needs to involve participation by people in the communities covered to achieve this. Services will then be more likely to reflect needs and priorities that are set by the population, and not just by providers.

In theory, this is an excellent move as primary care services have enormous potential to positively influence some aspects of the health of over 90% of the population who use primary care annually.

Harbour Health has made community engagement a priority and has developed the following plan to engage with its community in order to develop effective and efficient communication processes between primary providers and their communities.

#### Objectives:

- To develop formal processes for ongoing engagement with local community groups and populations.
- To use these processes as efficient conduits for regular two way communication regarding health issues, services and service planning.

Harbour Health has an enrolled population of approximately 147,000 people with diverse characteristics and associated needs. Within this community are numerous formal and informal community groupings that associate for a wide range of reasons, e.g. family and whanau, iwi, age, culture, religion, work, hobbies, education, sport and other mutual interests, social and health related needs.

One of the most efficient ways of engaging with this wide range of people is to identify the major groupings and discuss with each of them the potential for developing a Memorandum of Understanding (MOU) describing how Harbour Health and their organisation can effectively discuss and share information both ways.

To date (October 2007) eighty groups are included in the Harbour Health Community consultation network. Most of these have signed a formal Memorandum of Understanding (MOU) describing practical communication purposes and processes and identifying key contact roles. This process will allow relationships between the PHO and primary care to evolve and mature over time and not leave links to be dependent upon informal encounters and specific personalities. The network still needs to be extended to include additional Asian and migrant groups.

The next stage in community engagement is to formally consult with the community about specific issues. For example, a major issue already identified is lack of GP understanding of the existence and role of some NGOs leading to few or late referrals to services.

Many Community Groups have requested communication via a newsletter in preference to, or in addition to a Website. .

Harbour Health will maintain a continued focus on developing new and building on existing community relationships. As there is an improved understanding of the health needs of the enrolled population we will continue to work together to develop seamless services for patients.

Dr Jill Calveley  
Clinical Director

Dr Symphy Tindi  
Health Promotion and Clinical Programme Analyst



## **Achievements and Performance**

# Achievements and Performance

## Active Families



Active Families is a programme aimed at assisting children and their families into healthier, more active lifestyles. With weekly activity sessions and advice from a Dietitian, we aim to change the children's attitude towards physical activity, help them maintain a healthy weight and control medical conditions. As the name suggests it is not just about the child, it is also about the family. A parent is required to attend each session with their child because the support of the family is a vital component to success. We want to support, educate and encourage families to set goals for both lifestyle change and physical activity. The programme is currently running at ActivZone, Glenfield; AUT, Northcote; and recently added centres of East Coast Bays Leisure Centre, Browns Bay and Mahurangi College Gym, Warkworth.

### Participants in the Programme

Janice van Mil – Clinical Services Manager

Lis Cowling – Health Promotion

Partnership: Harbour Sport, Waitemata DHB and SPARC.

### Key Highlights and Achievements

- New resources include an Active Families Nutrition booklet and a Physical Activity booklet which support the programme.
- Case Study presentation on family in conjunction with Paediatrician from North Shore Hospital was at Starship Hospital audience of 50, broadcast across New Zealand, 17 DHB's tuned in for the presentation.
- Presentation to North Shore Public Health Nurses on programme expansion, referrals etc.
- Presentation to Senior Managers (GM's) from the WDHB re Green Prescription/Active Families and all Harbour Sport programmes.
- Presentation to North Shore City Council.

### Performance Measures Results

Objectives	Output Measures	Target	Results																								
To maintain and increase the referrals into the Active Families Programme	Promotion to: GP teams, WDHB, community workers, Physios, Public Health Nurses.  32 Families supported as at 30 June 2007	To have a maximum of 50 families supported through the programme	Feedback has shown a substantial increase in good nutrition and increased physical activity.  Participant comment: "Our household consists of 7 people and she is the youngest, she has changed everyones way of eating and has lost weight in the process."																								
To ensure the programme meets the needs of ethnic groups	To increase the number of Maori, PI and quintile 5 families on the programme.	25% of all participants	<table border="1"> <tr><td>NZ Euro</td><td>10</td></tr> <tr><td>Maori</td><td>6</td></tr> <tr><td>Tongan</td><td>3</td></tr> <tr><td>Indian</td><td>1</td></tr> <tr><td>Middle Eastern</td><td>1</td></tr> <tr><td>Russian</td><td>1</td></tr> <tr><td>Samoan</td><td>1</td></tr> <tr><td>Cook Island Maori</td><td>1</td></tr> <tr><td>Chinese</td><td>1</td></tr> <tr><td>African</td><td>3</td></tr> <tr><td>Fillipino</td><td>3</td></tr> <tr><td>Nuean</td><td>1</td></tr> </table>	NZ Euro	10	Maori	6	Tongan	3	Indian	1	Middle Eastern	1	Russian	1	Samoan	1	Cook Island Maori	1	Chinese	1	African	3	Fillipino	3	Nuean	1
NZ Euro	10																										
Maori	6																										
Tongan	3																										
Indian	1																										
Middle Eastern	1																										
Russian	1																										
Samoan	1																										
Cook Island Maori	1																										
Chinese	1																										
African	3																										
Fillipino	3																										
Nuean	1																										



# Achievements and Performance

## Active Families

Objectives	Output Measures	Target	Results
To ensure geographical venues meet the need of the community.	Evaluate the attendance numbers.	Programme accessible for the community where need is identified.	Hibiscus Coast Leisure Centre cancelled and East Coast Bays and Warkworth venues identified as high areas of need.

### Future Developments

- Developing a Pacific Island specific model to role out to the district.
- Developing a Maori specific model to role out to the district.
- Formal evaluation funded by WDHB will be carried out before June 2008.
- Programme now six months with the option to extend if needed (will ensure more families can access the programme).

# Achievements and Performance

## Asian Smokefree Communities



ASC (Asian Smokefree Communities) is a collaborative partnership between Waitemata District Health Board, Harbour Health and Auckland Regional Public Health Service, to create a culturally specific and appropriate approach that combines both smokefree promotion and smoking cessation in a family-oriented setting.

ASC provides phone counselling, advice, home or workplace visits, prescriptions for Nicotine Replacement Therapy, especially nicotine gum and patches, and information such as booklets, pamphlets and stickers.

ASC is a free service for Asian people who live in the WDHB area or are enrolled in Harbour Health.

ASC also provides free interpreter services.



### Participants in the Programme

Christina Lee and Zhoumo Smith – Co-ordinators

Administer and provide smoking cessation services using available languages and culturally appropriate approaches and resources. This includes visiting clients and their families to monitor progress as well as promoting smoke free cars and homes.

Steering Group –

Dr Robyn Whittaker (Clinical trials Unit University of Auckland)

Lis Cowling (Health Promotions, Harbour Health)

Janice van Mil (Clinical Services Manager)

Sue Lim (Manager Asian Health Support Services WDHB)

Janet Chen (Auckland Regional Public Health)

### Key Highlights and Achievements

- Pilot project based on the North Shore has been extended to the whole WDHB area since July 2007.
- A Ministry of Health funded, formal evaluation was carried out by Grace Wong (AUT University). This 'intention to treat' analysis found that the 93 ASC cessation clients who had access to some form of intervention had a self-reported quit rate (continuous abstinence) of 72.0% at one month, 53.8% at three months and 40.9% at six months.
- Professionally facilitated and organised promotional events such as seminars, and health promotion days.
- Relationship development with other smokefree coordinators and Korean community leaders
- Development of educational resources and display materials that are culturally appropriate and effective.



# Achievements and Performance

## Asian Smokefree Communities

### Performance Measures Results

Objectives	Output Measures	Target	Results
To increase ASC referrals.	Number of people referred to ASC.	100 referrals (04/2006-06/2007)	Received 155 referrals (110 active clients)
To promote ASC to the Asian community.	Utilise mass media. Organise seminars, workshops or health awareness days, etc.	Four press releases in newspapers throughout the year. Health day once a year. Seminars 2-3 times a year.	Press release about ASC (two magazines, nine newspapers) Press release about World Smokefree Day and ASC Weekly Korean newspaper article series Korea Town Korean magazine interview One hour Korean radio interview Korean Health Awareness Day Kiwi Ora Seminar Korean Church Seminar
To contact clients frequently according to the guidelines.	Number of contacts.	Average 10 contacts for each client through the year.	Total contact made 1,285 Average 10.7 contacts/client
To liaise with other smokefree coordinators.	Meetings, conferences, symposiums.		Participated in Smokefree symposium October 2006 Attended two Smokefree Auckland meetings Attended three Auckland Smoking Cessation Network meetings

### Future Developments

- Promote ASC to other ethnic groups and increase their referrals.
- Develop social marketing.
- Extend ASC service to be regional.

# Achievements and Performance

## Care Plus



Care Plus is a chronic care self-management programme provided and supported by the General Practice.

### Participants in the Programme

Rachel Lloyd – Primary Care Programme Manager

Other nursing members of the Clinical Services team

The team works with practice staff to provide support and education to assist with the delivery of the Care Plus programme in General Practices.

### Key Highlights and Achievements

- An information sharing meeting led by nurses who currently manage patients enrolled on Care Plus. They provided an overview of their experience and support for nurses beginning the Care Plus programme within their practice.
- Feedback from Practice Nurses involved with the programme, all reflect positive outcomes for patients and job satisfaction for the nurses involved.
- Implementation of specific Care Plus clinics at some smaller General Practices has led to increased uptake and sustainability of the programme.

### Performance Measures Results

- 88% of practices are now enrolling clients in the Care Plus programme.
- Harbour Health has a total of 5,659 eligible patients for Care Plus.
- By August 2007 a total of 3,218 patients had been enrolled which equates to 56.8% of eligible patients.
- Patient health outcomes show significant positive trends.

Objectives	Output Measures	Target	Results
To enrol 50% of eligible population.	Measure Care Plus enrolment data from practice registers.	50% eligible population.	56.8% of eligible population enrolled.

### Future Developments

- Harbour Health is developing a database reporting programme to assist in the analysis of outcome data from the Care Plus programme.
- Harbour Health is working towards a combined chronic care management framework, incorporating the Care Plus programme, CVD risk assessment, respiratory assessment and diabetes management.



## **Achievements and Performance**

### **Cardiovascular Disease and Diabetes Risk Assessment**

The aim of the programme is to improve the health outcomes of the enrolled population of Harbour Health through the introduction of a CVD and diabetes risk assessment and management programme.

#### **Participants in the Programme**

Rachel Lloyd – Primary Care Programme Manager

Harbour Health Clinical team members

#### **Key Highlights and Achievements**

##### **EDGE CVD and Diabetes risk assessment tool**

The highlight this year has been the development and completion by Comprehensive Health Services of CVD EDGE, a decision support tool compatible with Medtech32.

This tool has now been implemented in all practices affiliated to Harbour Health, and practice clinical staff education sessions will commence in November, with more planned early in 2008.

##### **WDHB CVD and Diabetes risk assessment Programme**

WDHB has initiated a district wide CVD and Diabetes risk assessment and management project. The initial planning phase for the implementation of this project is now underway involving all PHOs in the WDHB district. We are now working on the details of the funding model for primary care and the clinical reporting requirements for a population based screening programme. The proposed start date for this programme is 1st February 2008.

#### **Performance Measures Results**

To identify, treat and provide care packages for patients at risk of cardiovascular disease and diabetes.

#### **Target Population**

Following the National Heart Foundation, and best practice guidelines, the recommendation is to screen asymptomatic men 45 years and women from 55 years, and Maori, Pacific and Indian men from 35 years and Maori, Pacific or Indian women from 45 years. Those with other risk factors of CVD, such as Diabetes, should also be screened earlier, men from 35 years and women from 45 years. This equates to approximately 30% or 47,000 of Harbour Health's enrolled population. The target for this project is to risk assess 70% of this eligible population within the next four years.

#### **Future Developments**

We look forward to the finalisation of the project and funding plan with Waitemata District Health Board, and the implementation and continuation of this project within Harbour Health General Practices.

# Achievements and Performance

## Diabetes



### Participants in the Programme

Lynn Randal - Diabetes Programme Manager, Registered Nurse  
Lesley Sanderson - Dietitian/Diabetes Team Leader, Registered Dietitian  
Paul Carver - Intern Health Psychologist  
Tracy Money-Clarke - Green Prescription Manager  
Diabetes Centre personnel, North Shore Hospital

There are three parts to this programme:

### Diabetes Self-Management Education for Patients (DSME):

This is a five week course directed at educating patients within Harbour Health who are at risk of developing diabetes i.e. those who are glucose intolerant, have been newly diagnosed with Type 2, or have poorly-controlled Type 2 diabetes. Topics covered include pathophysiology, relevance of exercise, food groups, food labelling, virtual supermarket tour, associated complications, foot care, medications, treatment of hypoglycaemia and blood pressure. At the third session, all measurements are retaken, blood results discussed, lab tests explained and myths and facts explored. Community services and support groups are promoted. Currently three-monthly refresher sessions are offered to all who complete the course, with guest speakers such as health psychologist, retinal photographer, podiatrist or support group co-ordinator giving presentations.



### Key Highlights and Achievements

- From March 2007 participants have completed the Rapid Estimate of Adult Literacy in Medicine (REALM) questionnaire (which gives an indication of literacy level) prior to commencing the diabetes self-management education course. Results have been significant; participants with a higher level of literacy achieving better health outcomes.
- These were submitted and accepted as a poster presentation at the NZSSD/ADA/ADEA Conference in September 2007 in Christchurch.



# Achievements and Performance

## Diabetes

### Performance Measures Results

Objectives	Output Measures	Target	Results
<p>To develop, monitor and evaluate a community based, health professional led, Diabetes Self-Management Education group programme for people with Type 2 diabetes.</p> <p>Delivery of the programme based on the empowerment philosophy to develop the participant's self-confidence, knowledge and skills to enable them to make informed decisions regarding their diabetes care and self-management.</p> <p>To improve quality of life, diabetes control and reduce the risks of diabetes complications.</p> <p>To provide a safe venue where people with diabetes (and significant others) can share their experiences, feelings and frustrations, and be assisted to access appropriate support.</p>	<p>To meet DHB contract</p> <p>Patients pre and post course knowledge via questionnaire.</p> <p>Course evaluations by all participants.</p> <p>Clinical indices.</p>	<p>248</p> <p>Improvement in knowledge.</p> <p>Improvement in HbA1c, lipid profile, weight, waist, BMI</p>	<p>170 patients and support persons.</p> <p>Mean knowledge improvement 23%</p> <p>97% positive report back on session length and value.</p> <p>A significant improvement in all clinical indices and recordings for course participants at five weeks.</p>

### Future Developments

- To include presentations by health psychologist on motivation, mood and cravings.
- To increase the number referrals of people with Type 2 diabetes to prevent or reduce complications.
- To increase the number of referrals of people with pre-diabetes (IGT, IFG) to prevent diabetes.
- To enter WDHB Clinical Awards for 2008.

# Achievements and Performance

## Diabetes



### Practice Nurse Diabetes Education

Training in diabetes is provided for Practice Nurses from all PHOs in WDHB area, to ensure a high level of knowledge and competence, within the primary care nursing workforce.

### Key Highlights and Achievements

- Three two-day courses were offered in 2006 and two in 2007.
- Practice Nurses Receiving In-depth Diabetes Education (PRIDE) group for nurses who complete the course, including the Diabetes Annual Review (DAR) practical assessment, for on-going education, and updates.
- PRIDE newsletter.

### Performance Measures Results

Objectives	Output Measures	Target	Results
To deliver training in management of patient with diabetes.	Knowledge improvement using pre/post questionnaires.	Minimum of one nurse per practice to receive training.	Knowledge improvement 30%
To improve Diabetes Annual Review (DAR) uptake.	DAR observed and signed off before certification.	5% increase in DAR uptake.	Increase not achieved.

### Future Developments

- Increase in DAR uptake of 5% over 2007.

### Local Diabetes Team (LDT) Facilitation

The organisation of LDT meetings, collating and reporting Diabetes Annual Review (DAR) data to the DHB and Ministry of Health from all PHOs in WDHB area.



# Achievements and Performance

## Dietitian

### Clinics

The dietitian continues to provide nutritional information and support for patients with, or at risk of, chronic conditions on an individual basis for those not suited to the group setting. Facilitating a self-management approach has led to positive sustainable self motivated outcomes. Clinics are held throughout the community for ease of access.

### Participants in the Programme

Lesley Sanderson - Dietitian

### Key Highlights and Achievements

- Improved health outcomes and risk reduction.
- Positive feedback from majority of patients and referrers.

### Performance Measures Results

Objectives	Output Measures	Target	Results
To provide appropriate dietary information.	Improved health outcomes: QOL, Reduction of risk	All patients seen within 1 month of referral.	Health outcomes, risk reduction and feedback has been positive.
To ensure culturally appropriate information is given, in an appropriate manner.	Improved health outcomes in all ethnicities, especially the Maori, Pacific, Asian high-risk population.	Resources developed in 17 languages.	Numbers are reliant on referrals (ratio of ethnicities is equal to Harbour Health's population ratio).
To ensure venues meet the needs of the community.	Evaluate attendance numbers/contact non-attendees.	Venue close to patient's home or workplace, for ease of access; some after-hours clinics included.	Reduced number of non-attendees.

### Future Developments

- Statistical analysis of patient profile/numbers/outcomes.
- Development of electronic systems

# Achievements and Performance

## Dietitian



### Community Health Promotion

Working with Health Promotion team to raise awareness in the community regarding Healthy Eating Healthy Action and to inform the community of services offered by Harbour Health.

### Participants in the Programme

Lesley Sanderson - Dietitian

### Key Highlights and Achievements

The provisions of appropriate information, display, talk, microwave cooking demonstration and health checks at:

- Chinese Specific Health Awareness Day, 14 October 2006
- Older Adults Health Awareness Day, 26 July 2006
- Diabetes Awareness Day, 25 November 2006

### Performance Measures Results

Objectives	Output Measures	Target	Results
To improve health knowledge within Maori, Pacific Island, Asian and lower socio-economic communities thus reducing health inequities.	Number of events held throughout the year; appropriate organisations' participation. Survey forms.	To participate in events when requested.	Stronger links within community. Raising profile of Harbour Health and its affiliated practices.



### Cardiovascular Disease (CVD)

Working with Diabetes Team to provide group education for patients referred with CVD risk factors such as excess weight, hypertension or dyslipidaemia.

### Participants in the Programme

Lesley Sanderson - Dietitian

### Key Highlights and Achievements

- Improved service to patients with this one-off two-hour morning or evening session.

### Performance Measures Results

Objectives	Output Measures	Target	Results
<p>To develop, monitor and evaluate a community based, health professional led, group programme for people with CVD risk factors.</p> <p>To deliver the programme based on the empowerment philosophy to develop the participant's self-confidence, knowledge and skills to enable them to make informed decisions regarding self-management of their condition.</p> <p>To improve QOL and health outcomes.</p> <p>To provide a safe venue where people (and their significant others) can share their experiences, feelings and frustrations, and be assisted to access appropriate ongoing support.</p>	<p>To increase referrals to this improved service for patients with modifiable CVD risk factors.</p> <p>Course evaluations from participants; improved knowledge of participants.</p> <p>Improved clinical indices: weight, waist, body fat %, blood pressure, lipid profile.</p>	<p>To encourage all patients referred with excess weight, hypertension or dyslipidaemia to attend where appropriate.</p>	<p>Increase in attendance rates over 2006/2007.</p> <p>Feedback positive re content, value to participants and knowledge improvement.</p> <p>Clinical outcomes not monitored, as currently no group follow-up (patients can request individual follow-up appointments).</p>

### Future Developments

- To increase the number of referrals of people with CVD risk factors.
- To increase attendance.

# Achievements and Performance

## Health Awareness Days



The Migrant and Refugee Health Promotion Days are an initiative created out of the need to have health, lifestyle and chronic illness information available in a culturally appropriate and approachable setting. Language barriers are addressed by ensuring an adequate number of appropriate interpreters are available at all times, both for those who attend and for those who display. Feedback from the Community Elders shapes the topics for the Health Promotion Days.

### Participants in the Programme

Janice van Mil – Clinical Team Manager

Lis Cowling – Health Promotion

Partners: WDHB Asian Health Support Services, NZ Fire Service

### Key Highlights and Achievements

- Health Awareness Days, Chinese Specific Health Awareness Days, Older Adults Health Awareness Days, Home Safe Home, Diabetes Awareness Days, Week with Diabetes NZ.
- Whanau Health Event.

### Performance Measures Results

Objectives	Output Measures	Target	Results
<p>To increase health knowledge within Maori, PI, Asian and lower socio-economic communities thus reducing health inequalities.</p> <p>Cement close links with the communities we serve.</p>	<p>Number of events held for communities throughout the year.</p> <p>Appropriate organisations participate.</p> <p>Survey Forms.</p>	<p>Minimum of three events per year.</p> <p>An increase in enrolments within Harbour Health practices.</p> <p>An increase in community groups attending.</p>	<p>Further strengthening links within the community raising the profile of Harbour Health and its associated practices.</p>

### Future Developments

- Older Adults Diabetes Awareness Day, Positive Aging Centre – 15 November 2007
- Identification of other community groups who would benefit.



## Achievements and Performance

### Immunisation and Outreach Immunisation Service

The aim of the Immunisation and Immunisation Outreach Service programme is to plan, deliver and evaluate immunisation programme outcomes for practices affiliated to Harbour Health and their populations, with an ultimate goal of improving immunisation coverage rates. This includes all immunisations on the childhood schedule, annual influenza vaccination programmes, and any other immunisations excluding travel vaccines. This includes:

Assisting Primary Health Care providers by following up on families with children who have missed vaccination events. Outreach Immunisation Service (OIS).

Monitoring and assisting where necessary to ensure ongoing collection and transfer of accurate immunisation data from practice management systems onto the National Immunisation Register.

#### Participants in the Programme

Jane Williams – Programme Manager and Outreach Co-ordinator/Nurse

Allison Waretini – Immunisation Outreach Nurse (six-month contract 2006/2007, now completed)

#### Key Highlights and Achievements

- The development of a database to support Outreach referrals has been proven to be a valuable tool.
- Development of Harbour Health practice nurses database for assessing and updating authorised vaccinator status.

#### Performance Measures Results

Objectives	Output Measures	Target	Results
To achieve National target (95%) of fully vaccinated 2 year olds.	Quarterly audits from each Practice PMS system.	95%	87%
Influenza Incentive Programme.	Influenza vaccination data audited on PMS and sent to Harbour Health.	60% vaccination of eligible (funded) patients over the age of 75 years.	76%
To increase immunisation completion rate of OIS referred children.	Audit of data of children aged 0-1years referred to OIS.	Not specified .	40%

#### Future Developments

- Outreach referral database developed to streamline monitoring/auditing of referrals to the OIS and for reporting to the Ministry of Health as per the contract.
- To audit Maori and Pacific Island children immunisation completion data to assess the need for intervention specific to that population.
- To develop strategy (along with WDHB Immunisation Steering Group) to address barriers to missed vaccination opportunities at practice level.
- To develop Immunisation resource folder for Harbour Health Practice Nurses.

# Achievements and Performance

## North Shore Lifestyle Project



The Northcote Electorate of Birkdale/Beachhaven and Northcote has the highest percentage of Maori than any other area in (Te Raki Paewhenua) North Shore City. Approximately 19.6% of the population identify as Maori. The area is predominantly a low socio-economic area and is isolated from main shopping/business areas of the North Shore City.

Te Whanau O Tu Tonu is a group of volunteers who support the needs of their community.

Rationale: Te Whanau O Tu Tonu identified the need to create a structured and supporting environment to create a platform for culturally appropriate Lifestyle initiatives.

### Participants in the Programme

Janice van Mil – Clinical Team Manager

Lis Cowling – Health Promotion

### Performance Measures Results

Objectives	Output Measures	Target	Results
Strengthening communities approach to align with the HEHA strategy which will contribute to the overall aim of He Korowai Oranga in Whanau Ora.	Number of new appropriate initiatives.	Three new Lifestyle initiatives.	Kaumatua and Kuia involved in Line Dancing, Tai Chi, Kapa Haka.
	Increased communication with Whanau.	Newsletters and database to be developed.	Bi-Monthly newsletters sent and database 90% complete.
	Increased enrolments in Tu Tonu.	Raising the awareness of projects and opportunities available within Tu Tonu.	Information in school newsletters.
Aligning with the Whare Tapa Wha model of Health.	Culturally acceptable communication and education with Whanau.	Progressing demographic analysis.	Improved Health and Wellbeing for Whanau.
	Engagement with Youth.	Feedback surveys, hold Huis and focus groups.	Involvement of Youth within Tu Tonu to identify issues and discuss possible resolutions.
Developing Tu Tonu's volunteer workforce.	Identify areas for development within the workforce.	Identify and attend appropriate courses/workshops.	Parenting Inc workshop and Computer and Business course attended by Coordinator and Kaiwhakahaere.

### Future Developments

- Youth Forum to be developed to inform Tu Tonu.
- Demographic survey to be completed and service gaps identified.
- Build appropriate relationships within the wider community.
- Build appropriate service/provider linkages.
- Continue appropriate workforce development.



## Achievements and Performance

### Otago Exercise Programme

---

The Otago Exercise Programme (OEP) is a home based, strength and balance exercise programme. It is facilitated in partnership with ACC. This fully subsidised, 12 month, home based exercise programme is available to those over 80 years old, living in Auckland's North Harbour region (from Northcote in the South to Warkworth in the North). It is available across all GP Practices in the North Harbour Ward.

OEP Target Criteria is to deliver the Otago Exercise Programme to those:

- Over 80 years of age (Maori and Pacific Islanders over 65 years of age); and
- Who have a fear of falling, have fallen, or who fall frequently; and
- Who live within their own dwelling or a self-contained unit, residing in the North Harbour Ward.

In special circumstances, to give consideration to those who fall outside the above age criteria and who have suffered an injurious fall where an ACC claim may have been lodged as a result. Referrals which fall into this category are passed by the ACC IPC for consideration to enrol.

#### Participants in the Programme

Lis Cowling - OEP Programme Manager

Naseema Dutt - OEP Administration

OEP Physiotherapist team based in North Shore, Orewa and Warkworth

#### Key Highlights and Achievements

- Winning the ACC National Tender to continue to deliver the OEP until 2010 in the North Harbour Ward.
- Increasing the targeted enrolment numbers.
- Continued improvement of the OEP database to supersede ACC requirements and form the basis of programme CQI measures.
- The development of the OEP Scoring System has allowed greater insight into the effects of the OEP on participants and the associated resulting health gain.
- Raising the percentage of those who complete the programme to 38% from 22% proving the CQI measures put in place regarding participant motivation are working.
- Writing a submission on Harbour's OEP for the NZ Safety Awards.
- Celebrating another year of team retention and capacity building to accommodate contract growth.
- Continuing to build strong relationships with North Shore Hospital's outpatient services including the Home and Older Adults Service (HOAS), Allied Treatment and Rehabilitation (AT&R), Needs Assessment and Service Coordination (NASC), Community Physio's and Occupational Therapist's and the Acute Wards within the North Shore Hospital.

# Achievements and Performance

## Otago Exercise Programme



### Performance Measures Results

Contract Date	Contract Deliverables	How Measured
1st July 2006 – 30th June 2007	<p>Co-ordinate and deliver the Otago Home Based Strength and Balance Programme to 360 participants.</p> <p>Visits/phone calls for each participant.</p> <p>Documentation of any falls and record programme activity.</p> <p>Home safety checklist to be completed for each participant.</p> <p>Actively promote the benefits of strength and balance exercise for older adults in the community. Regularly update the Shore Safe older adult working group via the group's bi monthly meetings.</p>	<p>Referrals received.</p> <p>Database of participants maintained.</p> <p>Participants entering programme.</p> <p>Evidenced in monthly report.</p> <p>Calendars ordered and distributed.</p> <p>Evidence in monthly and final evaluation reports.</p> <p>Evidence of networking and fall prevention promotion with health providers and older adult groups.</p> <p>Record of Harbour Health participation in Shore Safe fall prevention working group's minutes.</p>
31st July 2007		Final evaluation report submitted to ACC.

### Future Developments

- Continuing Quality Improvement of the OEP programme to ensure it is exceeding the needs of the participants and requirements of ACC.
- Development of electronic referral system.
- Sustainability project with AUT's Never2old.
- Data analysis project. Analysis of hospital admission data received for those enrolled on OEP. These statistics will form the basis for improvements to not only the OEP but to the WDHB's NASC, HOAS and Acute Rehabilitation Services.



## Achievements and Performance

### Pharmacy Facilitator

---

#### Context

Shane Scahill provides clinical and project management services to Harbour Health and Comprehensive Health Services (CHS). There is significant cross over and synergy between the activities undertaken for CHS and the activities undertaken for Harbour Health. CHS activities are around clinical education and the safe use of medications which also aligns with the focus of Harbour Health.

#### Workstreams

There are a number of work streams being undertaken for Harbour Health:

- Project management of PHO Performance Program
- Community Pharmacy Development Plan
- Complementary and herbal medicines work stream
- Other national activities

#### The PHO Performance Framework

This national initiative has been going in the PHO since 1<sup>st</sup> January 2006. Shane Scahill initially led the development of the project and subsequent to full implementation has been handed over to Dr Michelle Trumpelmann as a GP Liaison and project manager. The clinical indicators which overlap with CHS activities and have been beneficial to discuss in Peer Group include: asthma and COPD, thyroid testing, acute phase response testing, and UTI testing.

This project involves the following work streams for Shane

- (a) Clinical governance – development of a robust clinical governance group including high calibre external representation
- (b) Information management – development of robust and easily interpreted reporting systems
- (c) Best practice development – identifying and supporting best practice approaches
- (d) Communication – imparting clinical and organisational information and feedback to member practices

The progress with this project has exceeded expectations and the Waitemata District Health Board (WDHB) and DHBnz are very pleased with the progress at Harbour Health.

The next phase of the PMP programme is being rolled out and over the next year will involve a focus on CVD risk assessment, management and reporting at the level of both the practices and the PHO. Likely future indicators from 1<sup>st</sup> July 2008 include cardiovascular and diabetes markers including HbA1c in diabetes, ACE inhibitors in diabetics with renal dysfunction, statins for secondary MI prevention and so on.

#### Community Pharmacy Development

Harbour Health has Shane Scahill working on Community Pharmacy Development Program. The Waitemata District Health Board formulated the Community Pharmacy Development Plan, which went out to district wide consultation. An Implementation Steering Group was formed with representation from Community Pharmacy, general practice, the DHB and PHO and DHB Integration Pharmacists. Two projects have been worked up. One includes Medicines Use Review (MUR) and Adherence Support. The other initiative involving community pharmacy is the DUMP campaign to aid the safe waste disposal of unwanted medicines.

# Achievements and Performance

## Pharmacy Facilitator

---



The MUR initiative is funded through the Waitemata DHB PBMA process and allows 25 of the 96 community pharmacies to be involved in the first year. MUR and Adherence support involves identifying those patients who are at high risk of not taking their medicines and having a structured approach to helping these patients through an initial face-to-face consultation between the pharmacist and patient with feedback to the GP. Patients are followed up to ensure the help is sustained. If needed blister packaging is provided to improve adherence.

The DUMP campaign included a pilot in the Rodney District. Every household in the Rodney District was mailed a flyer about the DUMP Campaign, which allowed people to return their unwanted medicines free of charge to one of 15 pharmacies in their district. Medicines collection was undertaken safely in pharmacies and the material collected and later recorded in a non-identifiable fashion by fourth year pharmacy students at Auckland University as part of their final year project. This pilot will provide some invaluable data, which is currently being analysed including a survey to the community.

### Other Activities

Shane Scahill is on the Board of the Clinical Advisory Pharmacists Association (CAPA), which is the national body representing pharmacy facilitators. This is of great benefit to CHS as the strong fellowship amongst these members means that a lot of information is shared as opposed to being generated by each IPA/PHO. There is strong collegial support from this evidence-based group which is important for facilitators who would otherwise be working in isolation.

Shane Scahill is on the Academic Advisory Board of the Goodfellow Unit as a Pharmacy representative and on the 08 Goodfellow Unit Symposium organising committee, as well as being a Board member of the Auckland PHO. Harbour Health indirectly benefits from these activities.

### Future Developments

The Harbour Health Board is committed to engaging with Community Pharmacy and has approved the election of a Community Pharmacist onto the Harbour Health Clinical Governance Group. Community Pharmacists are to be invited to appropriate large group CME.



## **Achievements and Performance**

### **Primary Care Nursing Professional Development**

To develop and implement a Primary Care Nurse Development strategy for Harbour Health, and plan and coordinate the CNE Programme and Professional Recognition and Development Programme (PDRP).

To develop and implement professional development sessions for primary care nurses, covering nursing competency courses for respiratory and diabetes management, immunisation updates and new programme updates and training as required.

#### **Participants in the Programme**

Rachel Lloyd - Primary Care Programme Manager

Janice van Mil, Wendy McNaughton, Jane Williams, Lynn Randall - Harbour Health clinical team nurses

#### **Key Highlights and Achievements**

##### **WDHB Primary Health Care Nursing Leadership group**

The establishment of a Waitemata District Health Board primary health care nursing steering group, chaired by Sue Adams, Primary Care Nurse Consultant.

This group has representatives from all sectors of primary health nurses in Waitemata DHB.

Rachel Lloyd was elected as the PHO representative to a steering group to develop a PBMA and business case proposal titled 'Professional and Workforce development Programme for Primary and Community Nursing'. This proposal has now been submitted to WDHB for inclusion in the 2007 PBMA process.

The aim of the proposal is to provide a coordinated programme of professional and workforce development for primary health care and community nurses in WDHB, resulting in a consistently competent and high performing workforce, which delivers high quality care as part of the wider interdisciplinary and intersectorial teams, maximising health outcomes of individuals, whanau and communities.

Initially, the proposal intends to:

- Develop the capacity and capability of the primary health care nursing workforce through a coordinated professional development programme across the sectors
- Recruit and support both new graduates and nurses returning to nursing practice, into primary care and community settings.

These strategies align with the national direction of primary health care nursing, and require dedicated and ongoing funding streams.

#### **Performance Measures and Results**

##### **Continuing Nursing Education**

Harbour Health provides Continuing Nursing Education, CNE, through Comprehensive Health Services for all practice nurses that are employed within practices affiliated to Harbour Health.

The Continuing Nursing Education programme continues to be well attended and regarded by Harbour Health's Practice Nurses. The monthly two hour evening sessions are attended on average by 30 nurses, with positive feedback from the individual session evaluations. The session topics are structured following annual consultation with the nurses and also follow Harbour Health's programme developments. Presenters are generally from organisations with the Waitemata area, or departments within WDHB, to provide district wide inclusion and education of specialised services available.

# Achievements and Performance

## Primary Care Nursing Professional Development

---



### **Professional Development and Recognition Programme – PDRP**

Nurses are required under the Health Practitioners Competency Act 2003, to show evidence of competency of nursing practice.

Practice Nurse's within Harbour Health are supported with their PDRP development by a memorandum of understanding between WDHB Nursing Development department and Harbour Health.

Harbour Health supports practice nurses by providing a nursing portfolio template, inclusion in peer groups if required, and support from qualified assessors, who assess the portfolios following WDHB PDRP guidelines. Assessed nurses then submit their certification to NZ Nursing council, to enable their practicing certificate to be issued for three years following assessment, without the need to be audited by Nursing Council. Approximately a third of Harbour Health's practice nurses have completed their portfolio assessments to the required standards.

This process also enables Harbour Health nursing development team, to assess the levels of nursing practice within our organisation, and identify areas that may require further education and support.

### **Future Developments**

Continuation of the work with the District Primary Health Care leadership group, to foster leadership within primary health care nursing, promote primary care as a career pathway for nurses, leading to workforce development and sustainability.



## Achievements and Performance

### Primary Options

An acute care programme, available to all General Practices in the Waitemata District. to appropriately manage acutely unwell patients in the community, for an episode of care of three to four days, and a budget of \$300 per episode, thus reducing referral/admission to hospital.

A range of community diagnostic, therapeutic and logistical services are provided at no extra cost to the patient (except the initial consultation). These include: radiology procedures, home visiting physiotherapy, home nursing services, home help, equipment hire, transport to and from primary care locations – mostly taxis, rest home care, and follow-up visits to general practice locations.

Services are accessible 24 hours per day, seven days a week. A call centre coordinates services after hours.

#### Participants in the Programme

Dr Maelen Tagg – Medical Development Adviser (Guideline development and audits)

Dr Lannes Johnson – Medical Advisor (Lannes assesses referrals for clinical safety and appropriateness)

Primary Secondary Liaison – Dr John Wellingham temporarily is filling this role

Pam Boyce – Service Manager

Sue Freeman – Co-ordinator

Robyn Diprose – Administrator

#### Key Highlights and Achievements

- Development of an electronic data base for referrals and invoicing which is currently being used successfully in house. Once the contract has been finalised with Healthlink the programme will be piloted for one month and then gradually rolled out to general practices across the WDHB district.
- The past year has seen an increase in referral rates of 14%, over the past 12 months.
- Dr Maelen Tagg has had a paper published in the NZ Medical Journal 7th September 2007: 'Accuracy of the Wells Rule in diagnosing deep vein thrombosis in primary health care'.
- A patient survey conducted in June 2007 showed that of the 27% who responded 80% thought that the Primary Options service was excellent 17% Good. 70% strongly agreed that it was an advantage to have care provided by a GP rather than hospital. There were also many positive statements about Primary Options and services provided.

#### Performance Measures Results

Objectives	Output Measures	Target	Results
Enable primary care teams to access new and existing community-based alternatives to acute hospital admission where these are appropriate.	Monthly reports on referrals by provisional diagnosis, by outcome, age, gender, ethnicity and referral by final diagnosis, by PHO as % of enrolled population.	12% managed out of hospital.	Targets met

#### Future Developments.

- Electronic data base for all practices in the WDHB.
- Extra funding for Accident related conditions. (Discussions currently underway between WDHB and ACC, see article in NZ Doctor September 2007).

# Achievements and Performance

## Push Play Neighbourhood – Warkworth/Mahurangi East



Community development project supporting clinical interventions and health education strategies promoting physical activity. Project is situated in semi rural/rural communities that are not as well serviced as urban areas, particularly in regard to community recreational facilities and sport development services.

The overall aim of the programme is a 5% increase in physical activity in addition to improved coordination and access to opportunities to be active. The intention is to create more options for people wanting to become more active and to better coordinate an approach to sustaining and promoting these options.



The project also has the objective of increasing referrals to programmes; both community led, and Harbour Sport led such as Green Prescription and Active Families. This programme links with other PHO clinical programmes – particularly diabetes, CVD, injury prevention and mental health promotion. The coordinator role creates a local contact to link community activity with clinical settings.

### Participants in the Programme

There is one paid coordinator, with the bulk of personnel resource coming directly from the community as they form a community collective. Community input and support of the programme is steadily increasing.

The project has a steering committee with representatives from funding partners – Rodney District Council, Harbour Sport, ACC, Coast to Coast PHO and Harbour Health. These meetings are attended by Harbour Health Clinical Services Manager.

The Co-ordinator is also supported by Health promotion staff at Harbour Health and works closely with Harbour Sport staff to better align their programmes with this neighbourhood project.

### Key Highlights and Achievements

- Formation of the Warkworth Neighbourhood Collective.
- Range of representation on the Warkworth Collective.
- Launch of Mahurangi East Neighbourhood project.
- Formation of Junior Sport sub group – need identified by the community.
- Collation of information for directory.
- Community activities underway – kids running, pram walking.
- Extensive community participation in Push Play Nation – schools, workplaces and Harbour Health practices.
- Positive community feedback for project and Co-ordinator.
- Regular media coverage and promotion



# Achievements and Performance

## Push Play Neighbourhood – Warkworth/Mahurangi East

### Performance Measures Results

Objectives	Output Measures	Target	Results
Engage with community in establishing the project.	Form a community collective. Inform key community groups about the project.	1 x collective Warkworth 1x collective Mahurangi East	Warkworth 100% underway. Mahurangi East launched.
Improve access to information about physical activity.	Compile a community directory of programmes and services.	Directory developed and distributed in the community (2000 copies).	Directory drafted and getting feedback from community. 75% complete  Regular newsletter and media communication occurring.
Increase co-ordination between services and activities in the area.	Documentation of programmes. Coordinator as central point of contact.	Develop and utilise tools and strategies to build up community infrastructure.	Network increasing in the community.  Harbour Sport activity/presence in the area increasing.
Develop new programmes and physical activity service.		5 new programmes developed or identified.	100% - 5 new programmes established/identified in both neighbourhoods.
Increase Push Play neighbourhood profile.	Measure attendance at events.	Complete two events by November.	100% - attendance at Kowhai Festival and Heart Foundation walk.
Develop promotional material for the project.		Produce logo and supporting resources.	100% complete - Newsletter, promotional items, marketing tools produced.
Increase referrals to Harbour Health and Harbour Sport programmes.	Measure referrals to programmes.	Target to be determined.	This aspect of the project will be worked on when community infrastructure more securely in place.

### Future Developments

- The Push Play Neighbourhood project is based on long term strategic effectiveness, aligning services and programmes to maximize impact on the community. In this first year the focus has been on building a network of providers and community representatives with the future focus to be on strengthening this group and formalizing the network further.
- The project has potential for effectiveness within clinical settings more ie stronger links with Green Prescription, better referrals into programmes. At this stage the focus is on building up better infrastructure within the community for people to be referred into.
- In the future when current programmes are better coordinated and participation rates increased, further new programmes and activities can be developed to respond to identified need in the community. However at the same time there have been several new programmes resulting from the project as well as increased profile and participation in what is already available.

# Achievements and Performance

## Respiratory



To provide an integrated respiratory service that aims to improve the management of respiratory symptoms for eligible people in the North Shore and urban Rodney district. It is based on providing education and support to the various respiratory programmes in the district with the emphasis on education for primary care providers and patients with respiratory symptoms.



### Participants in the Programme

Wendy McNaughton – Respiratory Programme Manager

### Key Highlights and Achievements

- Clinical development of Web based asthma assessment tool with decision support.
- Developed and presented Asthma Course to Practice Nurses in HealthWest and Auckland PHO.
- Developed an “Asthma Management in Schools” pack for school nurses to use with children with asthma.
- Attended an asthma “Train the Trainer” course in Wellington.
- Assessed PDRP portfolios for Harbour Health Practice Nurses.

### Performance Measures Results

Objectives	Output Measures	Target	Results
Provide Practice Nurse education in district.	Programme Effectiveness. Pass written test >80% Pass practical assessment.	Provide three Asthma Courses pa for Practice Nurses in Harbour Health, ProCare North and Te Puna Hauora PHO.  36 nurses in total.	Positive evaluation and audit. 100% pass mark achieved. 100% passed assessment. 29 nurses attended.
Provide education for HealthWest and Auckland PHO.	Programme Effectiveness. Pass written test >80% Pass practical assessment.	Provide one Asthma Course per PHO pa.  27 nurses in total.	Positive evaluation and audit. 100% pass mark achieved. 100% passed assessment. 22 nurses attended.
Ongoing education/Support.	Programme Effectiveness. Feedback.	Provide four GASP Groups for Practice Nurses in Harbour Health, ProCare North and Te Puna Hauora PHO.	Positive evaluation feedback. 144 nurses attended in total.
Ongoing education/Support.	Asthma Update Course. Written Feedback.	Provide four asthma update courses throughout May.	Positive evaluation feedback. 63 nurses attended.
Ongoing education/Support.	Improved patient symptoms of asthma/COPD.	To assist in patient assessments in person and on the telephone/email.	Positive patient outcomes, difficult to assess until computerised.  Positive Practice Audits.
Provide School Nurse education in district.	Programme Effectiveness.	Provide Education programme for school nurses.  Develop “Asthma Management in Schools” pack.	12 school nurses attended 12 schools have a pack on site with an assessment tool.



## Achievements and Performance

### Respiratory

---

#### Future Developments

- Population based and funded Asthma Project throughout the district.
- Installation and implementation of Web based asthma assessment tool with decision support.
- Extension of Harbour Health Asthma Course to other Waitemata District PHOs.
- Improved patient access to and staff training of spirometry, (including nursing and non-nursing staff).
- Improved Access to Pulmonary Rehabilitation Programme in the district.
- Community Education: There is potential to extend the range of general education about asthma and COPD to many NGOs and community groups.

# Achievements and Performance

## Retinal Eye Screening



This is a free, community based service for people with diabetes. Patients are referred to the service by their General Practitioner or Practice Nurse and are seen within three months for their first screening. As well as covering the North shore area, we travel to, setup and hold clinics at Wellsford, Warkworth, Helensville, Waimauku.

### Participants in the Programme

Kathy Dyer - Team Leader/Retinal Photographer/Secondary Grader

Deborah Pile - Enrolled Nurse assists photographer

Margot McDonald - Administrator/Co-ordinator

### Key Highlights and Achievements

We manage a very successful service which is evident in our low DNA rate (5%) and we are continuing to improve our service by utilising feedback received from our patient surveys which are conducted at each site annually.

As part of improving the efficiency of our service, we are being upskilled so that there is flexibility within the team to provide cover when needed.

### Performance Measures Results

Objectives	Output Measures	Target	Results
Screen patients to help prevent vision loss due to retinopathy.	Reduction in referrals to secondary care.	Screen patients within their follow-up date.	Screened 3217 patients.
Screen all new patients within 3 months of receiving a referral.	Maintain low DNA rate (5%).	Screen 3600 patients per annum.	
Educate patients and liaise with their GP's/health providers.	Continued education and upskilling.		
Fulfil our contract with the WDHB.			



## Achievements and Performance

### Services to Improve Access

---

To address the issue of health inequality by removing barriers to access, demographically appropriate services are available to those enrolled with Harbour Health and who are:

Maori, Pacific Island, Migrant and Refugee; or  
Lower Socio-economic.

#### **Podiatry**

This is a fully funded service aimed at early prevention, education and management for those with diabetes and chronic conditions. The aim is to maintain an active lifestyle thus reducing hospitalisation and the end result of amputation. Patients access the service via referral from their General Practitioner, Practice Nurse, Social Workers, and Physiotherapists working in the communities.

Referral is to a qualified Podiatrist (with special interest in diabetes), close to where the patient lives for ease of service access and for those who are unable to travel, home visits are arranged.

#### **WATIS – Waitemata Translation and Interpreting Services**

Language is a main barrier to accessing services in a timely manner.

To improve access to primary care, Harbour Health contract the services provided by the Waitemata Auckland Translation and Interpreting Service (WATIS) (a division of the Waitemata DHB Asian Health Support Services), to cover all main Foreign Dialects. This is a 24 hour 7 day service.

#### **Community Project Vouchers**

Harbour Health does not have an Access Funded arrangement within the PHO. This initiative will address not only the inequalities of timely and affordable access for our enrolled population but also reach the non-enrolled population in the same way.

A voucher to the value of \$35 is supplied to assist with the cost of the GP visit.

Maori, Pacific, Migrant, Refugee and low income peoples make up 100% of the target population. These vouchers are given to community based groups; Salvation Army, Women's Refuge (North Shore and Warkworth), Homebuilders (Warkworth) and Glenfield Community Centre.

#### **Mahurangi Adolescent Clinic**

The Sexual and Reproductive Health Strategy was released by the Ministry of Health in 2001. It provides an overall direction for improved sexual and reproductive health outcomes. It highlights the need to increase knowledge about safer sex and provide information on sexual health, the risk of STIs and on prevention early, diagnosis and treatment.

Health outcomes are worse for Maori and Pacific groups although these numbers are relatively low in the college context. Students are very much driven by financial constraints and providing this free service eliminates barriers to treatment.

#### **Palliative Care**

Providing funding to allow patients to access home based, Practice Team (General Practitioner, Practice Nurse) services at no cost, lifting the financial burden on patient and whanau in the last months of life.

Maori whanau, Pacific Fono and Asian families prefer to have family members die at home but often cannot afford the Practice Team services required, despite the hospice services provided. Inequalities exist for these people due to the lengthy waiting time for Hospice services resulting in undue emotional and financial stress on patients and their families.

#### **Radiology**

Where an x-ray or ultra sound is required by the General Practitioner for the wellbeing of the patient and the following criteria is met:

- The waiting list at the hospital is too long and the patient may be detrimentally affected if they have to wait;
- The patient does not have private medical insurance;
- The patient cannot afford to pay for the procedure; the procedure will be paid for by Harbour Health.

# Achievements and Performance

## Services to Improve Access



### Skin Lesion Removal

Providing funding to allow the patient timely access to GP lead, practice based, skin lesion removal. This initiative has been successfully running in excess of six years.

### Psychologist

An essential component of the internship is clinical work with individual cases. The cases seen by the intern will generally focus on either ameliorating the psychological impacts of the clients physical health conditions, or assisting the client to manage the psychological factors that might bear on management of their physical health condition. In either instance this might involve assessing and testing mood and anxiety problems associated with chronic care management.

### Participants in the Programme

Janice van Mil – Clinical Services Manager

Paul Carver – Psychologist

Lisa Hampson – Business/Financial Support

Lis Cowling – Health Promotion

### Performance Measures Results

- 54% were either quintile 5 or held community services cards.
- 27% were Maori or Pacific Island.
- 15% identified hardship.
- 4% unknown.

This shows that Harbour Health and its general practices are targeting those at risk and with high needs.

SIA Service	Results
Podiatry	632 Referrals. High risk patients seen up to 3 times annually.3% of referrals require more intensive treatment.
WATIS	Referrals into the service – 206 with the majority being Korean.
Community Project Vouchers	112 patients were supported.
Mahurangi Adolescent Clinic	115 consultations.
Palliative Care	667 consultations.
Radiology	200 X-rays/Ultrasounds.
Skin Lesion Removal	157 excisions.

### Future Developments

- Continual monitoring of SIA usage to ensure that the needs of the targeted enrolled population are met.



## **Financials**

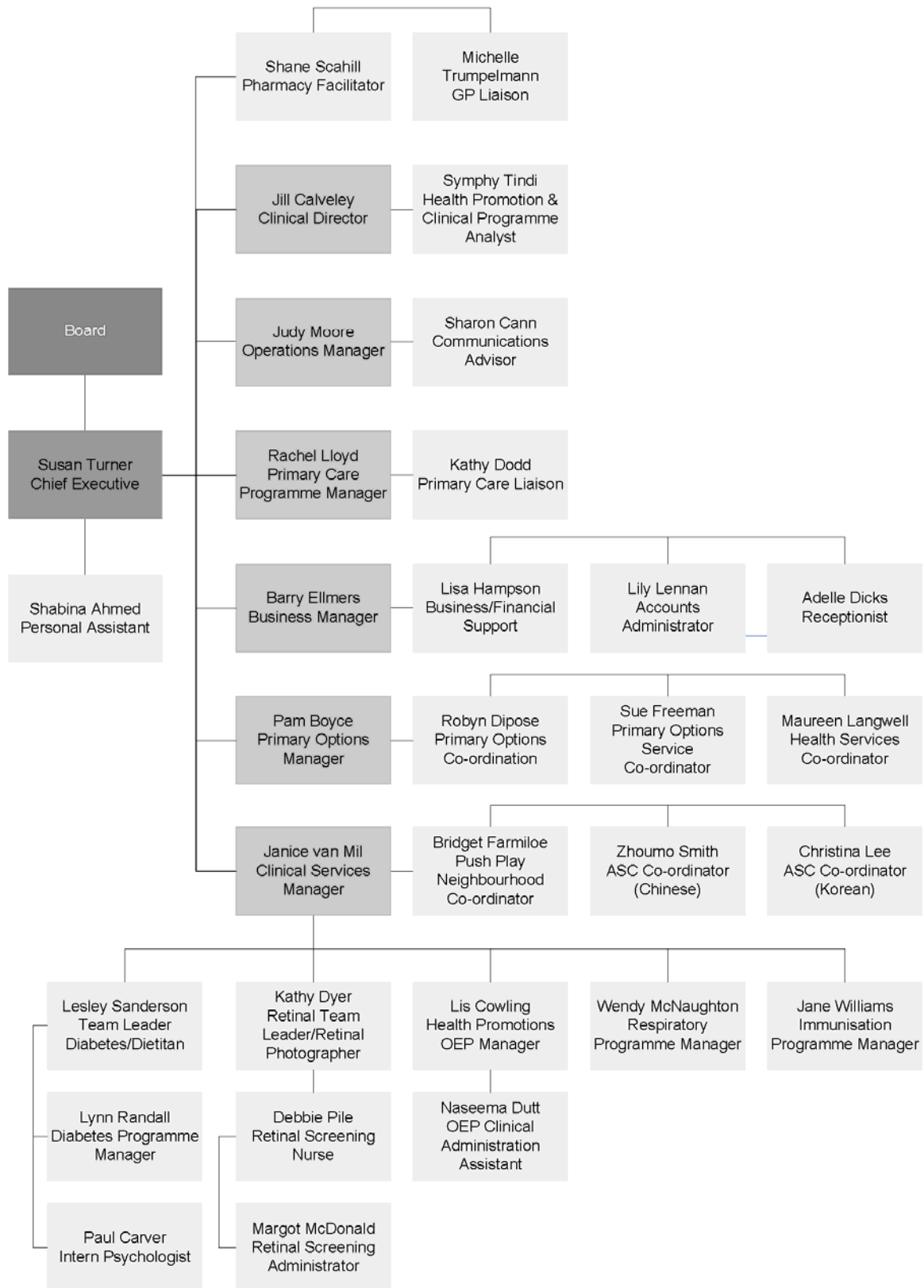
**To Be Provided  
Under separate  
cover**



## **Our Structure**



# Our Structure Organisation Chart



## Our Structure

### Board Members

---



#### **Dr Kate Baddock (Chair)**

Kate has over 21 years experience in both New Zealand and United Kingdom rural General Practice and is currently a partner with seven other General Practitioners at a Warkworth Practice. Her enthusiasm is for sports medicine and the management of chronic diseases. Kate is also involved in teaching undergraduate medical students, postgraduate doctors and registrars in General Practice training programmes.



#### **Dr John Arcus**

A North Shore General Practitioner for over 21 years, John has a strong passion for General Practice and all facets of quality health care – clinical, managerial, cultural and governance. John supports the Primary Health Care Strategy which places the patient together with their closest health adviser (organised General Practice) at the centre of the health care spectrum.



#### **Dr Warren Groarke**

Warren is a partner at Silverdale Medical and part owner of a Mt Eden corporate health clinic, Well for Life. Warren has a strong interest in Sports Medicine and has been appointed as the Tall Blacks doctor, Medical Director for Basketball NZ men and is currently the Auckland Rugby Football Union development team doctor. He is also a GP trainer.



#### **Dr Helen MacDonald**

A General Practitioner for 17 years, initially in a small suburban practice and currently as a founding partner in the Medical Centre @ Apollo. Helen is passionate about providing quality, sustainable primary care. She feels privileged to have been elected onto the Harbour Health board and is enjoying working with an innovative and dedicated team.



#### **Jane Retimana**

Jane-Renee is the Ngati Whatua (Tihī Ora) board director on the Harbour Health Board and represents the interests of Maori within the PHO. Jane-Renee is of Ngati Whatua and Nga Puhi descent and has been born and raised on the North Shore. Her working background is in the Justice Sector as a Manager with the Ministry of Justice.



#### **Carol Ryan**

Currently Manager of Raeburn House, a community based mental health promotion organisation, which interfaces collaboratively with communities and agencies across the Waitemata region. Carol has a Certificate in Health Promotion and is currently working toward a Graduate Diplomas in Not for Profit Management.



#### **Paddy Sullivan**

Paddy is a New Zealand Registered Nurse with over 31 years experience in primary health care in the Rodney District. She has worked as a Practice Nurse, Postnatal Care Nurse, in community eldercare and is currently employed as the Rodney Alzheimer's Advisor as well as the Qualcare Day Stay Team Leader. Paddy is an executive member of Rodney HealthLink and has served on school and church committees.



## Our Structure Affiliated Practices

Albany Basin Accident & Medical	Cnr Unsworth Drive & Upper Harbour Highway, Albany	443 7777
Albany Family Medical Centre	368 Albany Highway, Albany	415 8959
Archers Medical Centre Ltd	130 Archers Road, Glenfield	444 9324
Beachhaven Medical	330 Rangatira Road, Beachhaven	483 6422
Belmont Medical Centre	3 Williamson Avenue, Belmont	445 1215
Birkenhead Medical Centre	4 Rawene Road, Birkenhead	419 1636
Browns Bay Family Doctors	65 Clyde Road, Browns Bay	479 4834
Browns Bay Medical Centre	32 Anzac Road, Browns Bay	479 5422
Byron Chambers Medical Centre	2 Byron Avenue, Takapuna	486 2122
Devonport Medical Centre	82 Lake Road, Devonport	445 8006
Family Medicine Birkenhead	29 Birkenhead Avenue, Birkenhead	480 7204
Fenwick Medical Centre	3 Fenwick Avenue, Milford	486 3248
Glenfield Doctors on Chartwell	52 Chartwell Avenue, Glenfield	441 2352
Glenfield Medical Centre	452 Glenfield Road, Glenfield	444 5911
Hauraki Medical Centre	308 Lake Road, Takapuna	489 5059
Healthzone, Millennium Institute of Sport & Health	17 Antares Place, Mairangi Bay	477 2090
Highbury Medical Centre	121 Birkenhead Avenue, Birkenhead	419 2180
Dr Serene Hu	185 Queen Street, Northcote	480 9309
Kitchener Road Medical Centre	174 Kitchener Road, Milford	489 4092
Kowhai Clinic	424 Glenfield Road, Glenfield	444 2098
Kowhai Surgery	10 Percy Street, Warkworth	09 425 7358
Drs M and J Lockwood	93 Birkdale Road, Birkdale	483 7228
Massey University Health Clinic	Gate 5, Bldg 100, Oaklands Road, Albany	443 9783
Medical Centre @ Apollo	cnr Rosedale Road and Apollo Drive, Albany	477 3700
North Harbour Medical Centre	4/326 Sunset Road, Mairangi Bay	479 2083
Onewa Doctors Surgery	225 Onewa Road, Birkenhead	418 3832
Shakespeare Medical Centre	57 Shakespeare Road, Milford	486 3097
Silverdale Medical	4 Silverdale Street, Silverdale	09 427 9997
Snells Beach Medical Centre	347 Mahurangi East Road, Warkworth	09 425 5055
Sunnynook Medical Centre	119 Sunnynook Road, Sunnynook	410 5331
Sunset Road Family Doctors	Unit 3/317 Sunset Road, Mairangi Bay	478 2878
Takapuna Healthcare	25 Braken Avenue, Takapuna	489 5867
Torbay Community Doctor	987 Beach Road, Torbay	473 9594
Torbay Medical Centre	1042 Beach Road, Torbay	473 0348
Waiake Medical Centre	1 Hebron Road, Waiake	478 7660
Warkworth Health & Medical Centre	9 Alnwick Street, Warkworth	09 425 8549
Dr Lincoln Wong	423 Lake Road, Takapuna	489 6850

# Our Structure

## Contacts

---



Building B  
42 Tawa Drive  
Albany  
Auckland



PO Box 302-163  
North Harbour  
Auckland 0751



09 415-1091



09 415-1092



[info@harbourhealth.org.nz](mailto:info@harbourhealth.org.nz)



[www.harbourhealth.org.nz](http://www.harbourhealth.org.nz)