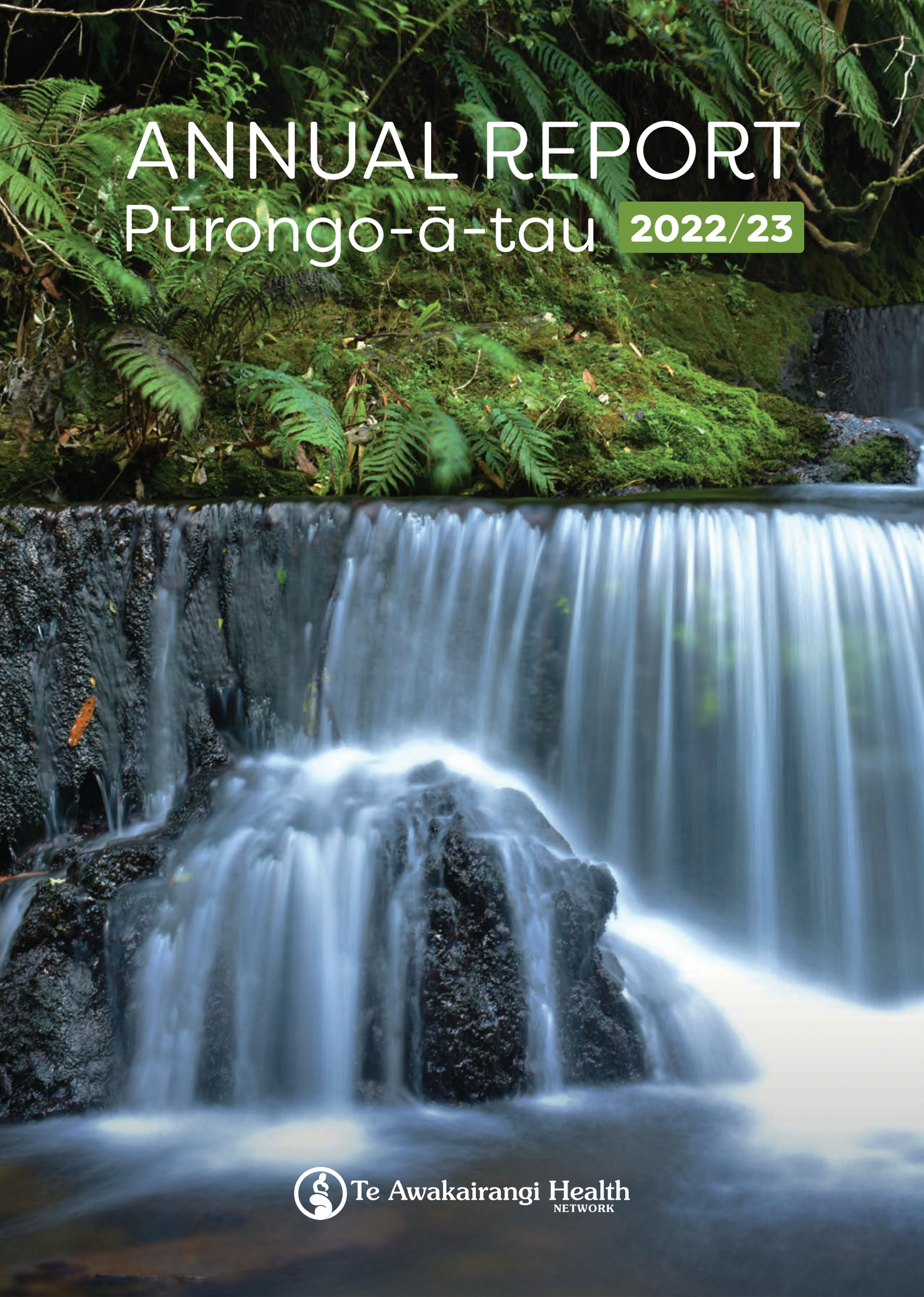


ANNUAL REPORT
Pūrongo-ā-tau 2022/23

Te Awakairangi Health NETWORK

Te Awakairangi Health
NETWORK

General Practices in the Hutt Valley

He Whare Haumanu ki te Awakairangi

Avalon Medical Centre

Connolly Street Medical Centre

Gain Health Centre

High Street Health Hub

Hutt City Health Centre –
Raroa Road and Wainuiomata

Hutt Union & Community Health Services –
Pomare, Taita and Petone

Kōpata Medical Centre

Mānuka Health Centre

Naenae Medical Centre

Petone Medical Centre

Queen Street Medical

Ropata Health

Soma Medical Centre

Stokes Valley Medical Centre

The Doctors Muritai

The Doctors Silverstream

Upper Hutt Health Centre

Waiwhetu Medical Centre

Whai Oranga O Te Iwi Health Centre

Lower Hutt After Hours Medical Centre

“Kei ā tātou te ara tika - the answers lie within us all”

A MESSAGE FROM THE BOARD CHAIR AND CE

He kōrero whakataki nā te Heamana me te Tumu Whakahaere

2022/23 has been another challenging year for the communities across Te Awakairangi / Hutt Valley, as the flow-on from the economic impact of COVID-19 and continued housing shortages have increased pressure on families and individuals, especially those on lower incomes. It has also been a difficult year for the primary and community care providers, including general practices, as staff illness and workforce shortages, along with a backlog of work from COVID-19 combined to create significant pressure.

Our general practices have also been impacted by the lack of action towards an equitable and sustainable funding system, despite the findings of the Waitangi Tribunal on the WAI2575 claim and years of advocacy by many. We were heartened by the visit of Minister of Health, Dr Ayesha Verrall in April 2023, when she heard directly from those working in general practice and are hopeful that the new Government will act to significantly improve the funding and strengthen support for our workforce.

Despite these challenges, our providers and our teams have worked hard to provide the care and support that has been needed by our communities.

Highlights for the year include intensive efforts to catch up on immunisations and other prevention programmes, increased uptake of community radiology and acute care interventions, improved results for people with diabetes, innovation in partnership with community pharmacies, and collaborative efforts to improve urgent and afterhours care.

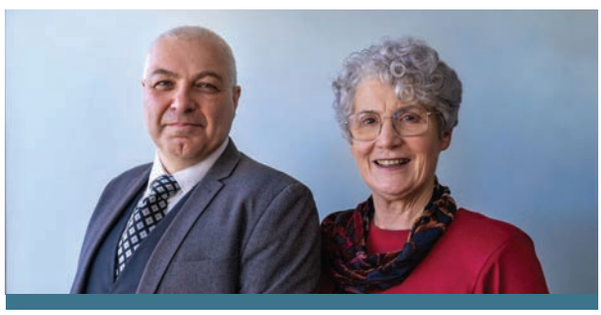
In 2022/23, we have continued our journey towards improved Māori health and health equity across this rohe, with our Board commissioning an independent cultural audit early in the year and then committing to implementing the audit recommendations. We are looking forward to working closely with Āti Awa Toa Hauora Partnership Board, Te Rūnanganui o Te Āti Awa, Takiri Mai Te Ata and our local marae leaders as they grow and strengthen the influence of Māori values and tikanga within the wider health system during the coming years.

It has been a year where we have recognised significant contributions to health in the Hutt Valley. We were saddened by the passing of Dr Kara Puketapu who was a visionary and leader of Te Āti Awa and one of the founding members of our Board. Moe mai rā te Rangatira. Haere, haere, haere atu rā. We were delighted when both Dr Kolitha De Silva (senior GP and partner at Naenae Medical Centre) and Nanai Mua'au (CEO at Pacific Health Service Hutt Valley) were recognised with Queen's Service Medals for their services to health.

A sincere thanks to all the staff, and members of our Board and Board subcommittees for their commitment, effort and mahi, making a positive difference to health in the Hutt Valley.

M N (Joe) Asghar
Board Chair/Heamana

Bridget Allan
Chief Executive/Tumu Whakahaere



Joe Asghar and Bridget Allan

He pitopito kōrero mō Te Awakairangi Health Network

Te Awakairangi Health Network aims to improve the health and wellbeing of the 160,000 people living in the Hutt Valley through effective primary health care and supporting the work of our general practices and partner organisations.

Across all our activities, Te Awakairangi Health Network has committed to fulfilling its responsibilities under Te Tiriti o Waitangi and to addressing equity issues, particularly by improving access to care and health outcomes for Māori, Pacific, low-income people and others at risk of poor outcomes.

As a Primary Health Organisation (PHO) we cover almost 115,000 people enrolled across 17 general practices. Under other contracts, we work with all 19 general practices, afterhours services, community pharmacies, radiology providers, podiatrists, Māori providers, Pacific providers, and mental health NGOs across Te Awakairangi / Hutt Valley.

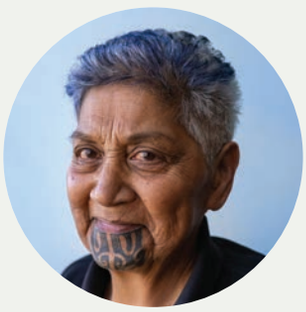
Overarching Strategic Priorities
Ko ā mātou whakaarotau rautaki matua

Our four strategic goals are:

- Improved wellbeing for people and whānau
- Connected equitable and accessible healthcare
- Enhanced and sustainable primary care
- Participation in Pae Ora environment

Muhammad Naseem (Joe) Asghar – Chair

Dr David Young



Peggy Luke-Ngaheke

Dr Mike Haymes

Muriel Tunoho

Dr Dougal Thorburn

Rev Vaega'au (Au) Liko

Jon Herries

Our Board – 2022/23
Mana Whakahaere

The work of Te Awakairangi Health Network is overseen by a Board that is made up of clinical and community representatives and an independent chair. These trustees set the strategic direction of our organisation and provide governance of activities carried out by the Network. The Board's focus is to ensure that our overarching goals are met and that equitable health services are being delivered to our enrolled population and others living in the Hutt Valley.

CARING FOR PEOPLE

Kia Atawhai ki te Tangata

Throughout 2022/23, we have aimed to assist our providers and our teams to maintain access and deliver high quality care in ways that reduce inequities and improve the health outcomes of the people of the Hutt Valley.

Moving to the new normal

After the significant efforts to respond to the COVID-19 pandemic, our response in 2022/23 scaled down but continued to require flexible planning and service delivery to meet the changing needs of the Hutt Valley, and we continued collaborative relationships with local Māori and Pacific providers to reach our high need communities.

Our large community vaccination sites were scaled down and closed, but we continued to offer vaccination at community events, our own pop-up vaccination events and through a mobile in-home vaccination programme. We supported our local Māori and Pacific providers with their outreach vaccination programmes, including a regular weekend clinic at Brewtown in Upper Hutt.

The COVID-19 Care in the Community model established in February 2022 continued through 2022/23, with our teams supporting the clinical care across the general practices and coordinating our manaaki efforts with those of Te Rūnanganui o Te Āti Awa and Takiri Mai Te Ata. Over the year, our general practices provided care for more than 11,800 people with COVID-19, while our manaaki team looked after over 3700 bubbles covering more than 10,500 people.

COVID-19 staff numbers dropped steadily across the year as demand for support reduced, but we retained a small workforce pool to enable surge capacity. This team was also able to offer some support to our general practices to catchup with work that was postponed during the COVID-19 response, particularly prevention efforts such as immunisations.

Prevention and screening services

Prevention and screening services are generally showing positive results, given the workload pressures and staffing shortages. Despite significant efforts, childhood immunisation rates have been slightly lower than in the previous year, reaching 84% overall at 8 months, reflecting wider community concerns about vaccination. 75% of eligible people received a CVD risk assessment, with no equity gap. Pacific people were the group with the highest uptake (79%) reflecting the great work of Pacific Health Service nurses embedded in several general practices. Our teams continue to support the screening services for cervical and bowel cancer.

This year, we have employed a Screening and Recall Facilitator who is working closely with practices to drive effort and educate staff. This will help practices to increase accuracy in recall systems and address the lower uptake of prevention and screening programmes across the valley since COVID-19. We are already seeing encouraging results from this effort.

Extending primary care

Our team continued to manage programmes that extend primary care with diverse programmes, including skin lesion removal, palliative care, and contraceptive access. The community radiology programme was well used in 2022/23 with more patients being managed in the community than in previous years, and with similar uptake by Māori, Pacific and Other ethnicities.

The POAC (Primary Options for Ambulatory Care) programme aims to reduce hospital admissions by offering extended care in the community. Given the pressures on Hutt Hospital, it was pleasing to see significantly higher utilisation of the POAC programme in 2022/23 compared to previous years, with higher utilisation by Māori patients.

While our general practices have been under pressure, during the year they have strengthened their efforts to support patients with Long Term Conditions (LTC), such as diabetes, respiratory conditions, heart conditions and mental distress. For people with diabetes, the percentage with good blood sugar control has improved since last year (up from 59% to 62%) with improvements across all ethnicities. Some of our practices are offering shared medical appointments to assist groups of people with diabetes with health improvement and self-management.

CASE STUDY

Shared Medical Appointments

The Naenae Medical Centre general practice team have hosted shared medical appointment sessions with diabetes patients and the LTC nurse, clinical pharmacist, health coach and a health improvement practitioner. These medical consultations are run in a supportive group setting and have shown a considerable drop in HbA1c. This Health Care Home tool responds to the reality that many clinicians face of struggling to meet a patient's more complex needs in a 15-minute appointment meaning that these patients often feel rushed and are not well equipped to self-manage their condition.

"I had the typical Māori man bravado and didn't understand the ramifications of having diabetes. Nothing at the sessions was morbid, it was informative, and the advice was good from everyone so I am beginning to manage my diabetes more. I still go to the club with the boys and I have shared what I've learned as they all have diabetes too and are in denial. I can talk about some brilliant pathways – diet and not smoking – I have back up now."

MIKE EDMONDS – SHARED MEDICAL APPOINTMENT PARTICIPANT

Top: Quang-Te Ly (Clinical Pharmacist at Naenae Medical) and client Mike Edmonds.

Bottom: Sue Colman (HIP at Naenae Medical) and client Mike Edmonds.

Improving access to care

Our Network offers services which improve access to care, particularly for Māori, Pacific and low-income people. These include interpreter, transport, primary mental health, and outreach (social work, community health work and nursing). The outreach services have seen increasing social and clinical complexity in the lives of the clients they look after, reflecting the impact of low incomes and housing shortages.

Before I met the outreach nurse, my health was terrible. I was sick a lot of the time, I felt really low and depressed. I didn't take my meds. I didn't understand my health and I just kept to myself. It's been awesome the way she talks to me and explains to me about stuff like taking my medicine, getting to the doctors and also connecting with other agencies. I have become more outgoing, I don't feel depressed, I'm doing what I should and my health is really good. I feel confident about getting out meeting other people and services on my own now.

WILLIAM, OUTREACH PATIENT

CASE STUDY

Supporting vulnerable and complex patients through outreach nursing

"When I first started as an outreach nurse nine years ago, the referrals we received were straight forward; we'd check blood pressure, help with diabetes management or medication compliance and transport to medical practices or specialist services. In the last few years, and especially since COVID-19, referrals are much more complex in nature."

Retiring outreach nurse, Trish Kerr, believes that her sixteen years' experience at the Hutt Hospital psychiatric unit early in her career gave her valuable tools for connecting meaningfully with outreach patients to effect true behaviour change.

"What may seem like a straightforward referral, for example trying to re-engage a diabetes patient with general practice for a medication review is the tip of the iceberg once we get to see the patient at home. Housing issues, financial stress, food poverty and unemployment, caring for sick family members, poor transport options and limited childcare to attend appointments are frequent examples of what I see. Their own health is often not the most important issue for them."

Quality Plan 2023 – 2026

Our latest Quality Plan was developed through an inclusive and collaborative approach, with the most impacted groups sharing their lived experience to inform and direct the key focus areas. These include recipients of services (consumers/patients and their whānau) as well as deliverers of services (health staff and health professionals). It involved consultation with key stakeholders through surveys, focus groups and interviews. The critical 'patient voice' enhanced and guided developing the focus areas.

STRENGTHENING GENERAL PRACTICE

He Manaaki Whare Haumanu

In 2022/23 we continued to support our general practices, as they transitioned from the intensity of focus on COVID-19 back to business-as-usual (albeit with higher demand).

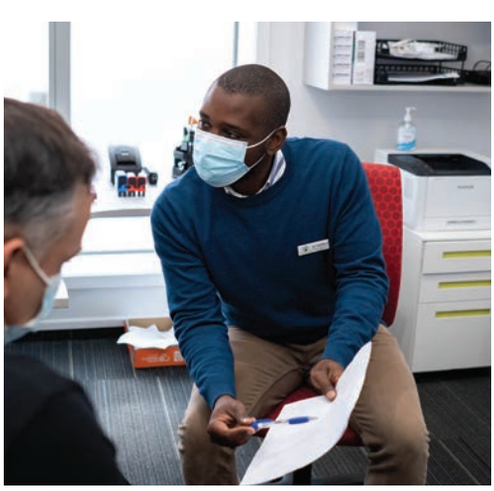
Workforce

Many practices are facing workforce challenges, with retirements and resignations of both GPs and practice nurses. Our Network ended 2022/23 with a slight improvement in general practice staff (with 1,806 patients per GP FTE and 1,929 patients per practice nurse FTE) compared to the same time the previous year, however, we remain concerned about the prospects for 2023/24, with more retirements expected, insufficient numbers of clinical staff in training, and continuing difficulties with overseas recruitment.

Recognising the workforce shortages in practices, our Board have allocated funding to support practices to employ and train NETP nurses (Nursing Entry to Practice for newly graduated nurses).

NETP Nurse

In late 2022, the Network employed our first NETP nurse under this scheme. Having gained the necessary competencies and experience for this specialised role, we were delighted when the nurse joined one of our practices in June 2023. We expect to attract more NETP nurses in 2023/24.



Expanding the primary care teams

We have continued to expand the primary care teams by embedding more Te Awakairangi staff in the general practices, with clinical pharmacists now working in 15 out of 18 practices, alongside social workers and outreach nurses.

One of the highlights of 2022/23 has been the continued expansion of the Access and Choice primary mental health service which has integrated Health Improvement Practitioners (HIP), health coaches and community support workers into 17 out of 18 general practice teams (up from 11 at the end of 2021/22).

CASE STUDY

Access and Choice working for General Practice

More general practices are seeing the wider health benefits of offering the Access and Choice service for their patients and Avalon Medical Centre is no exception. Dr Alan Chin says that the Access and Choice programme, "really helps by having someone who is available immediately to provide a safe space for people to work through what's on top for them".

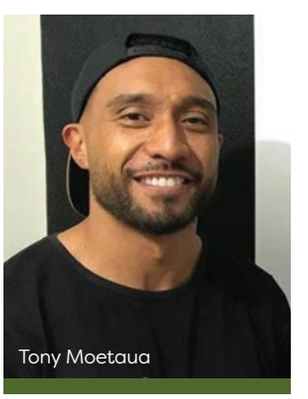
Dan (Health Coach) and some of the Avalon Medical Centre team.

CASE STUDY

A health coach can be the catalyst for change

Tony Moetaua and his team of health coaches undertake more than 400 consultations each month, either with new clients or existing whaiora. Many patients walk away after one or two sessions with more tools in their kete. For others, a conversation with a Health Improvement Practitioner or the support of a health coach can lead to a lifestyle change that transforms their life and the life of their family.

Tony began working with Mele (*name changed) who had moved from Auckland to the Hutt Valley to support her late sister's husband and their children. Five years earlier, Mele had been given an uncontrolled diabetes diagnosis, but had not acted on any advice. Run off her feet as the sole provider for five people, she knew something had to change. With an HbA1c reading of 117, Mele and her sister's aiga embarked on a programme of fitness, health literacy training, dietary improvements education sessions. After 12 months, her HbA1c reading is now 51 and she feels confident in managing her diabetes.



Tony Moetaua

The Health Care Home (HCH) model of care assists practices to give patients improved urgent and unplanned care, increased proactive care and more effective routine and preventative care, all with a focus on equity and Māori health. There are 15 Hutt Valley practices now using the model, covering 87% of the Hutt Valley population.

The model encourages practices to improve the patient experience of care, in part by offering patient portals and telehealth options. Patient portal coverage continues to grow with more than 57,000 (50%) of our enrolled patients connected.

A friendly ear

Our Programme and Practice Development team advocates for and supports our practices. With many new staff taking up roles in our practices in the past two years, the team provide a friendly ear and practical advice for all enquiries, be it day to day business or clinical issues.

The team continues to run high quality professional development opportunities for clinical staff, practice managers and administrators. They connect members of our Network to a range of external education and training promoted through our regular Bulletin, and organise specific education sessions, including well-attended training sessions for the ACC-funded GP MRI programme that saw 34 doctors trained in the year.

Afterhours care

In 2021, practices asked Te Awakairangi Health Network to investigate ways in which we could reduce the burden of afterhours shifts for our GPs, while maintaining or enhancing patient access to afterhours care. Over 2021/22 and 2022/23, we have participated with other PHOs in the establishment of Practice Plus, a virtual telehealth service which is complementary to general practice. In 2022/23, 2,087 patients (across all of our practices) used Practice Plus for a virtual GP consultation, with high levels of patient satisfaction, and reasonable uptake by priority groups such as Māori and Community Services Card holders.

We expect that this service will increase patient access to afterhours care, but more needs to be done to assist providers in the Wellington Region to meet the demand for both afterhours and routine general practice care. Recently, we and our PHO partners (Tū Ora Compass Health and Ora Toa) commissioned a review of urgent and afterhours care that will make suggestions for future improvement opportunities and the investment needed from 2023/24 onwards.

FROM TOP: 1. From Left – Mr Marcus Bisson, Dr Roland Ng, Dr Melanie Avery, Dr Bregt Haylen, Dr Hugh McCabe and Dr Gulshan Kaul attending Skin Lesion Training.

2. Practice Manager Training

3. From Left – Dr Cheyenne Heka, Dr Jake Aitken, Dr Su Domingo and Physiotherapist Thomas Keef attending GP Referred ACC MRI Training

Te tauritenga ā-hauora me te koke whakamua i te hauora Māori

We are looking forward to significant change arising from the work of the new health agencies. We were delighted when Te Aka Whai Ora provided specific 18-month funding for our two Hauora Māori practices to undertake or extend initiatives for better care of people with long term conditions. In what we hope will be a sign of things to come, since January 2023 three of our practices have been benefitting from the Primary Care Equity Adjustment funding.

In December 2022, our Board met with Hikitia Ropata, the Chair of Āti Awa Toa Hauora Board (our local Iwi Māori Partnership Board) and we are looking forward to further engagement in 2023/24. We welcome more opportunities to strengthen relationships with a range of providers and organisations, and to expand the use of pro-equity approaches to improve population health outcomes.

Cultural Audit and actions

Early in 2022/23, our Board commissioned an independent cultural audit to review our progress in addressing the challenges and opportunities arising from the "Hauora" report of the Waitangi Tribunal (following the WAI2575 claim) and the Pae Ora health reforms, and to guide our actions to build enduring Treaty partnerships and improve health outcomes for Māori. While commending elements of our Network's work to date, the audit team also recommended several ways we could improve, and our Board and senior leadership team have committed to implementing these.

We have established and employed a Kaiwhakahaere (GM Māori and Population Health) who sits at the Executive table, to lead the organisation's work in population health with a specific focus on improving Māori health outcomes.

Kaiwhakahaere Māori

Bobby Bryan (Ngati Porou) is very proud to have been born and raised in Wainuiomata and his career has spanned health and social service agencies across the country. In a short time, Bobby has established strong rapport among staff and his GM peers at Te Awakairangi Health Network. He is an enthusiastic leader of weekly waiata practice, a pou of knowledge and guidance, always encouraging our staff on their development and understanding of Te Ao Māori. Bobby has already met with several general practice teams and delivered cultural training and support, which will continue in 2023/24. Working with our corporate services team, he has also helped to update many of our Human Resources policies and procedures so that they reflect our commitment to Te Tiriti o Waitangi.

Te Mauri - Whakamana Māori Whānau with Cancer

Te Mauri cancer support group operates under Mana Wāhine (within the collective of Takiri Mai Te Ata) and focuses on a holistic Māori model of care for cancer patients and their whānau. It is the only Te Tiriti o Waitangi focused, mātauranga Māori cancer support service within Aotearoa/NZ and is based in the rohe of Te Awakairangi. Our Board funded Te Mauri from January 2022 to June 2023 and supported them in preparing a business case to secure ongoing funding, which has now been successful.

Māori Health Dashboard

The Amiorangi secure practice portal continues to provide information to improve patient care and focus on improvement in equity of outcomes. Practices have been very positive about the value of the Māori Health and Equity, Long Term Conditions and other programme dashboards. In 2022/23, our teams expanded the dashboards and provided training sessions so that practices are better able to use the information to improve the quality of services, to give more equitable access to services and to achieve greater business efficiency.

CASE STUDY

Using health information to improve Māori health outcomes

Dr Jake Aitken has been a strong proponent of the Māori Health and Equity dashboard at Waiwhetu Medical Centre (WMC) where over 40% of enrolled whānau are Māori. He is using the dashboard to better understand the health needs of the WMC patient population, what conditions they have, what treatments they are on, and if the practice is helping them achieve targets and milestones with their health.

"We pull the Māori Health and Equity data, the MMR data, the Flu data (in winter months) and the LTC funding data each month and combine it with other regular query builds we run and then discuss this data in our monthly clinical governance hui. This allows us to have a regular focus on how we are tracking against our goals to ensure we are improving specific measures and outcomes for our whānau. We find the Amiorangi graphs helpful for tracking our trajectory with the main KPI targets."

"The Missing Patient Status function has given the practice better oversight and ease to create lists of enrolled whānau for nurses and PCPAs to target through phone calls and texts and identify lists to find target whānau for our weekend clinics."

Dr Jake Aitken – Waiwhetu Medical Centre

DELIVERING TOGETHER THROUGH TIMES OF CHANGE

E whakarato tahi ana i te wā o te panoni haeretanga

Strong relationships with health and social care providers and community organisations are a key part of how we deliver services to our community. This includes prevention, early intervention, keeping people well at home, and empowering people to be active participants in their own health and wellbeing. COVID-19 reinforced our understanding that we can achieve more by working together and with other partners than by working alone.

Pae Ora seeks a wider population health approach that addresses the wider determinants of health as well as an integrated health and care delivery system. We are working alongside partners to maximise opportunities to strengthen the sustainability and resilience of the Hutt Valley health system within the new health arrangements.

Relationships with community pharmacies

Over the past decade, our clinical pharmacists have connected with the community pharmacies across the Hutt Valley, sharing information and developing innovative prototypes to support our communities, such as a groundbreaking minor ailments service pilot that was adopted nationally by Te Whatu Ora and a pharmacy-based afterhours service in Upper Hutt.

CASE STUDY

Minor Ailments Service Prototype

Our Clinical Pharmacy Lead, Barbara Moore, worked with five community pharmacists to develop a Minor Ailments Service (MAS) prototype in Upper Hutt at the end of 2022. The prototype design allowed a pharmacist to provide advice on, and treat, common and minor illnesses with a range of medications, and offered referral to a medical practitioner if additional care was required. In June 2023, Te Whatu Ora launched the nationwide community pharmacy minor ailment service pilot (based on the Upper Hutt prototype) as part of the Minister of Health's 2023 Winter Plan.

PHOs can play a crucial role in supporting innovative ideas to increase access and improve patient care at a local level. During 2022/23 Te Awakairangi Health Network was pleased to support Queen Street Pharmacy (in conjunction with Queen Street Medical) to meet the Upper Hutt community's need for afterhours care. With Te Whatu Ora, we are now exploring how this might be applied in other communities.

CASE STUDY

Pharmacy-based afterhours care

Queen Street Pharmacy owner Brooke McKay was regularly being faced with increasing patient complexity, inequitable access to medicines and health care services, a lack of acute after-hours care in Upper Hutt and fewer clinicians to deliver the services needed. With support from the Network, Queen Street Pharmacy and Queen Street Medical Centre have leveraged support from the virtual service, Practice Plus, to provide the community with improved access to acute care, especially in the afterhours space.

Under this model, patients are triaged and treated by a nurse or pharmacist, or where appropriate, offered Practice Plus appointments by the pharmacy (on their own device or via a computer in a private room). The service covers consultation with a doctor, urgent care clinician or nurse practitioner within extended opening hours.

Brooke McKay, Queen Street Pharmacy owner (left) with Karis Harland, Registered Nurse

Our relationships with community pharmacies have also enabled greater access to Rheumatic Fever prevention interventions, for people aged 3 to 35 years. In addition to our general practices, 21 of the 30 community pharmacies in the Hutt Valley are now able to assess and treat for Strep A, including symptomatic household members. The Network has also delivered training to local pharmacists, Pacific Health Service, Marae services, GPs and nurses on the awareness, assessment, treatment, and prevention of Group A streptococcal throat infections.

Population health

Our Network recognises the critical role that local government plays in enhancing the wellbeing and resilience of our local communities, whether in pandemics (like COVID-19), in climate change mitigation and adaptation, or providing the infrastructure that supports healthy lives. We have been pleased to participate in and support the activities and leadership of Healthy Families Hutt Valley across the two cities, as they facilitate changes that enable our people, whānau and communities to live healthier lives. We supported several health events with funding and staff representation, including men's health (Toso Vata, run by Pacific Health Service) and staff wellbeing (managed by Hutt City Council).

Our strong working relationship with Pacific Health Service Hutt Valley (PHS) over many years has delivered many health promotion initiatives (such as Pasifika Choice and Toso Vata) and highly integrated COVID-19 vaccinations and care in the community. We have also supported integration across primary mental health services, linking our general practices, Access and Choice team and Wellbeing team with the Toloa team at PHS. Several PHS nurses are now embedded into our general practices with high Pacific populations where they are already making a difference with improved uptake of CVD risk assessments and immunisations (especially MMR) for Pacific patients.

Members of the PHS Primary Care Team (Left to Right) – Amanda Matautia, Shivashni Narayen, Anoushka Alo, Fofoga Logovae, Talalelei Faifai.

Data and Digital team simplifies processes behind the scenes

Our Data and Digital team are supporting better patient care in many ways, relying on strong working relationships with many health providers and IT system providers to facilitate local implementation of digital healthcare improvements. They have implemented a simplified system for electronic referrals from general practices to Te Awakairangi Health Network services, ensuring relevant information is shared in a timely and paperless way. The team have also persevered with efforts to improve primary-secondary communication, including improvements to e-referral forms from general practice to Hutt Hospital, advocating for improvements to the volume of messages being received by general practices, and modernising some antiquated processes.

To enhance the care that Pacific Health Service staff give to Pacific patients, our Data and Digital team provide support through data capability and dashboards.

Te Awakairangi Clinical Director Dr Musab Hassan (second left) and Scott Fisher GM Data & Digital (far right) discuss possible improvements to digital systems with local GPs.

Wider health sector relationships

General Practice New Zealand (GPNZ) actively promotes strong, sustainable and well-resourced primary care in an integrated system. They advocate on behalf of general practice and PHOs (to address the issues of underfunding, under-investment, insufficient workforce and training opportunities) and coordinate primary care advice to, and connection with, decisionmakers in Government, Manatū Hauora, Te Whatu Ora and Te Aka Whai Ora. Through its PHO members, GPNZ covers an enrolled population of more than 4.4m New Zealanders, including more than 80 per cent of the enrolled Māori population.

Scott Fisher (centre back) with GPNZ Ngā Matapihi o te Wairua/Māori Leadership colleagues.

Key leaders at Te Awakairangi Health Network sit on GPNZ member rōpū: Bridget Allan, our Chief Executive, is a member of the GPNZ Executive Committee, and our GM Data & Digital, Scott Fisher (Ngāti Whawhakia, Ngāti Tahu/Ngāti Whaoa) is co-chair of the GPNZ data and digital leaders' group. Scott and our Kaiwhakahaere Bobby Bryan (Ngati Porou) sit on Ngā Matapihi o te Wairua, the GPNZ Māori leadership rōpū that offers health equity leadership in primary care to contribute to the collective effort of improving access for Māori.

We also value our membership of **Collaborative Aotearoa** and their support for the practical tools that support the evolution of primary care (such as the enhanced Health Care Home model of care and telehealth/virtual care). Earlier in 2023, we were pleased to offer one of their training modules, Collective Action with Communities, to our own staff and to the staff of our general practices and partner organisations, to build our local skills as a foundation for future place-based planning and integration. In May 2023, the Network assisted with funding three Māori staff from local organisations (alongside one of our own staff) to participate in Te Ara Ako o Collaborative Aotearoa international study tour, focusing on indigenous health and integrated care.

Te Ara Ako o Collaborative Aotearoa delegates pictured on the Canadian leg of their tour.

CASE STUDY Indigenous Leadership

Our GM Services, Carrie Henderson, felt privileged to be selected to take part in the Te Ara Ako o Collaborative Aotearoa tour that was focused on indigenous leadership and equity of outcomes for priority populations. Carrie along with three others from Hutt Valley health sector organisations - Healthy Families manager Eddie Edmonds, GP Dr Jake Aitken and Director of Hauora Dinah Rea from Te Rūnanganui o Te Āti Awa - visited the UK, Belgium, and Canada to share and learn about integrated care systems as well as build strong connections with the host organisations. The tour delegation gained fresh perspectives and experiences to support the health reforms and multi sector collaboration and will be presenting their findings from the tour at the 2023 Collaborative Aotearoa conference, focussing on "*Catalysing Change to Deliver Equity for Whānau*".

1 GP per **1,806 patients**

1 practice nurse per **1,929 patients**

1,555 clients received outreach services (52% Māori, 23% Pacific)

2,087 patients (from all Network practices) used Practice Plus for a virtual GP consultation

50% of enrolled patients are using a patient portal (31% Māori, 24% Pacific)

14,509 community radiology procedures (16% Māori, 7% Pacific)

84% of eight month old immunisations completed (72% Māori, 87% Pacific)

75% of eligible people had an up-to-date CVD risk assessment (75% Māori, 74% Pacific)

21 community pharmacies and 15 practices able to assess and treat suspected Rheumatic Fever

FINANCIAL STATEMENTS

Ngā Tauākī Pūtea

For our Financial Statements and Statement of Service Performance, go to:
www.teawakairangihealth.org.nz/documents/

The name, Te Awakairangi, means 'esteemed' or 'precious' and was originally given to the Hutt River in the time of the Ngai Tara settlers. It was bestowed on the Network by one of the founding Trustees, Dr Ihakara (Kara) Puketapu, of Te Rūnanganui o Te Āti Awa, when Te Awakairangi Health Network was established in 2012.

Remutaka te maunga

Remutaka te maunga
Rere ana te awa ki te Whanganui-a-Tara e... hei!
Tararua ngā hiwi
Pukeātua, Te Whiti
Te Awakairangi ē

Whaia te tika, me te aroha
Manaaki tangata ē
Nā ngā Ātua, te mauri ora
Te Awakairangi ē..... hei!

Remutaka is the mountain
The river runs through the valley to the harbour of Tara
The Tararua ranges
Pukeātua. Te Whiti
Te Awakairangi
Strive for what is right, strive for love
(Understanding) to care and empower all
By the gods, the essence of life
Te Awakairangi

This waiata is a contemporary piece composed by Rawiri Hirini for Te Awakairangi Health Network. This waiata tautoko encompasses the major features of our rohe and echoes the values of the Network and the collaborative working needed to succeed.


Te Awakairangi Health
NETWORK