Annual Performance Report

2020–2021

Pinnacle® Midlands Health Network

Pinnacle™ Incorporated

Contents

Introduction

For Pinnacle and our practice network, the 2020–21 year was characterised by continued COVID-19 management and recovery. While this proved challenging, it was rewarding to make significant progress in delivering the Group strategy.

In April 2021, the Government announced radical system reform, the biggest health structure change for a generation. It is no surprise that this announcement is now shaping our strategic planning and delivery of healthcare for the future.

This Annual Performance Report is a comprehensive summary of the highlights, challenges, milestones and discoveries experienced by Pinnacle during the 2020–21 operating year. Throughout the following pages, we reflect on the progress of our strategic goals and performance against key system level and organisational measures.

As our team continues to work towards these goals, there are some highlights from over the past 12 months that their commitment has enabled us to progress and achieve. These include:

- organisational governance, funding and cultural foundation for Māori health equity
- the increased development of our Māori leadership with Te Taumata Hauora
- engagement and work with our practice network, specifically strengthening rural care
- an increase in mental health service capacity and capability supporting general practice
- progress in our contribution to environmental sustainability.

We recognise that, like most areas across the country, we need to improve performance in national health indicators for immunisation, cervical screening, and smoking brief advice. We also acknowledge the equity gap in these areas for our Māori population. Improving this is a high priority for the 2021–22 year.

No crystal ball could have predicted the impact of COVID-19 these past 12 months, nor the current pandemic environment we find ourselves living and working in, but our network of teams and practices can be proud of what has been achieved. We thank them all for that.

Our vision to deliver primary care that supports all people to thrive by realising their health and wellbeing potential has guided us through these past, current and future challenges.

Mai i te kōpae ki te urupa, tātou ako tonu ai.
From the cradle to the grave we are forever learning.

Helen Parker
CEO
October 2021

Craig McFarlane
Chairman

Strategic goals

Primary care nursing
Recognise and enable excellence in nursing as an essential pillar of primary care

Child and youth
Create connections to improve access to primary care and empower young people to live well

Health equity
A targeted approach to health outcome achievement

Living well
Establish healthy lifestyles and proactive wellbeing for ageing adults

Maternity and early childhood
Support the best possible start in life. Integrated care for hapū māmā to achieve the best possible outcomes for pēpi and whānau

Living with multimorbidity
Enable people with more complex health concerns to receive appropriate care and live the life they choose

General practice
Support our general practices to thrive as primary care hubs within their communities

Rangatahi Māori
Culturally appropriate primary care for rangatahi Māori to achieve better health outcomes

Mental health
Earlier intervention to support mental wellbeing

Ageing well later in life
Convenient and appropriate primary care to maintain and improve quality of life for the elderly

Rural health care
Improve access to primary care services for people living in our rural communities

A greener environment
Better choices for a better future

Network overview

The Pinnacle network covers most of the Midlands region. It stretches from the south Taranaki coast to Gisborne in Tairāwhiti, and from north Coromandel to Turangi in southern Lakes. We support diverse urban and rural communities, with the largest rural primary care network in Aotearoa. Rural health and rural communities are central to our work.

Across Pinnacle's 87 practices, the number of enrolled patients has risen by 10,000 in the last three years. This increase is largely due to the population growth in the Waikato.

This growth has taken the total number of patients Pinnacle looked after to 511,443 patients.

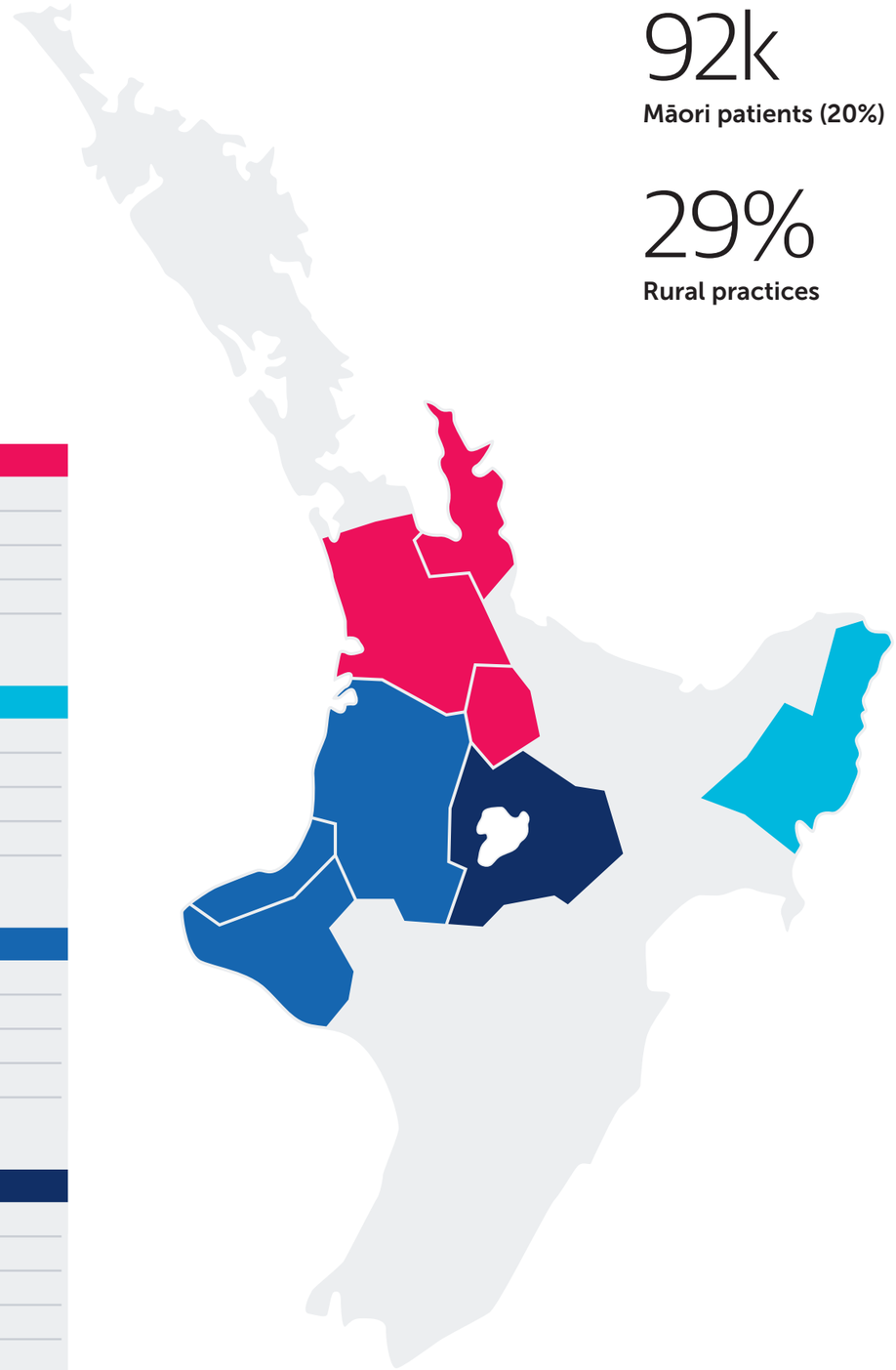
The network has been relatively stable with one practice joining the network as a result of acquisition and no practices leaving.

PINNACLE NETWORK STAFF	
GP FTE	271.4
Nurse FTE	294.2
Nurse Practitioners	16
MCA/HCA	78

452k
Total patients

92k
Māori patients (20%)

29%
Rural practices



WAIKATO
45 practices
252,210 total patients
41,292 Māori patients
162.95 GP FTE
159.9 nurse FTE

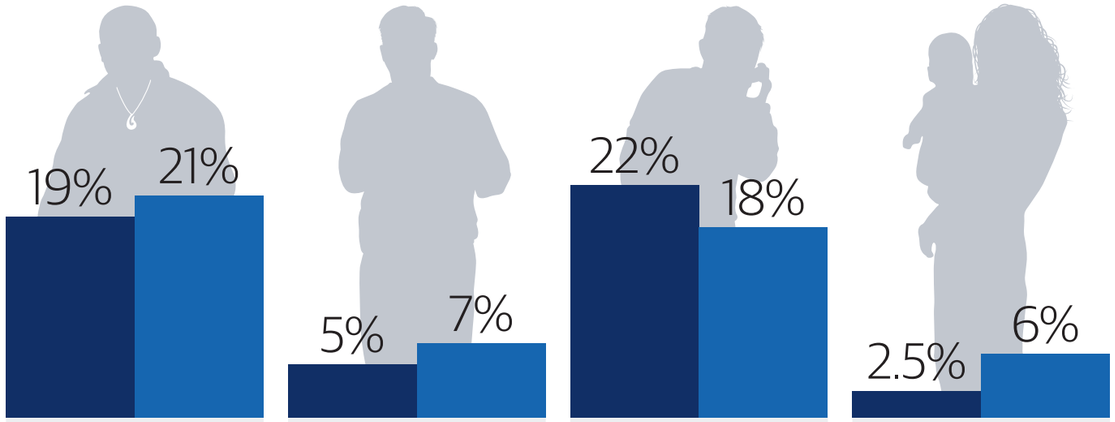
TAIRĀWHITI
5 practices
40,504 total patients
16,970 Māori patients
25.2 GP FTE
26.45 nurse FTE

TARANAKI
31 practices
115,679 total patients
20,428 Māori patients
63.35 GP FTE
76.55 nurse FTE

LAKES
6 practices
43,988 total patients
13,963 Māori patients
19.9 GP FTE
31.3 nurse FTE

Demographic changes

Compared to the 2018/19 year, we cared for:



What's driving these changes?

The biggest gain in 0–4 year olds is in the Asian infant demographic, which has increased 32 per cent since 2019–20. Māori infants have also increased 25 per cent in the same period and are keeping pace with European infants, whose growth rate is slowing.

For older patients, European and Māori people both see small declines, whereas Asian people have had a 9 per cent increase since 2019–20.

32%

Increase in Asian infant demographic

25%

Increase in Māori infant demographic

Practice workforce

Our practice workforce remains committed to delivering on Pinnacle's health care promises, but COVID-19 fatigue is very real. The network is reporting significant pressure due to an increase in complexity of care and general patient administration.

The graphs on the following page show our urban workforce FTE is relatively stable. However, our rural GP workforce is declining.

We are seeing a shift towards a higher ratio of primary care nurses and our nurse practitioner numbers are increasing every year.

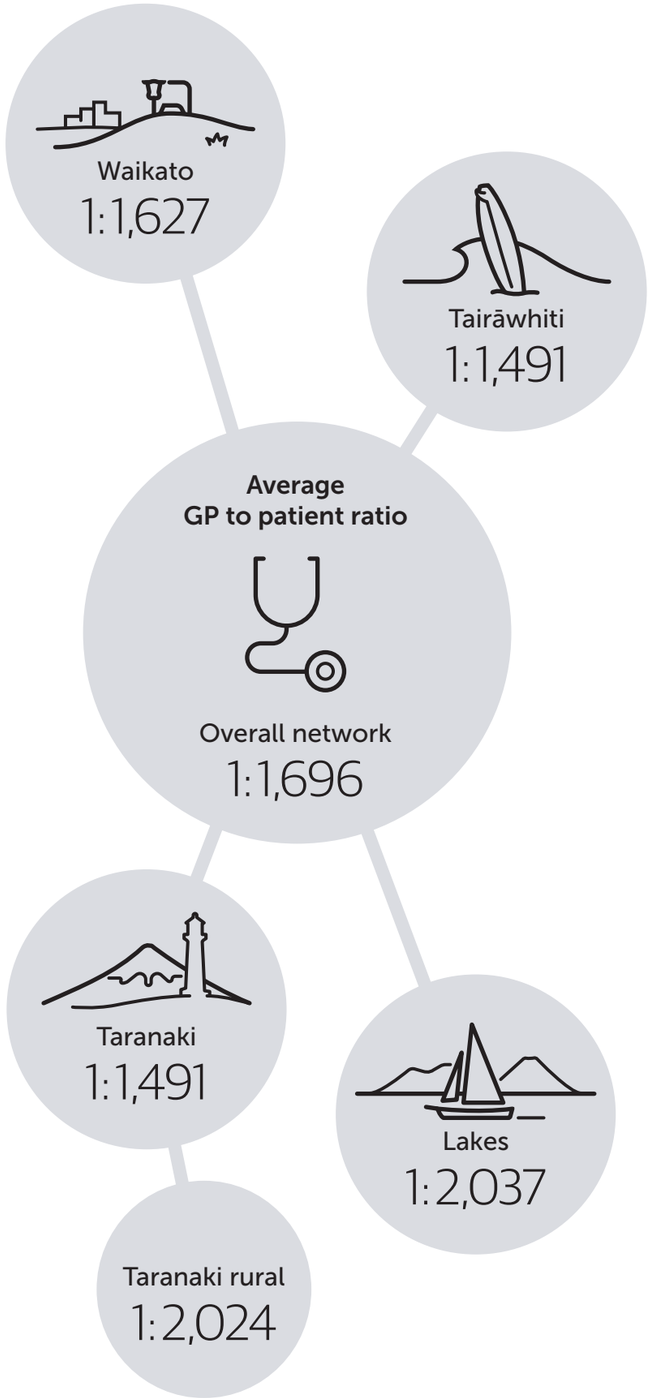
We are also seeing an increasing trend among practices employing business managers to either replace the traditional practice manager or complement it.

Practice-based extended roles, such as social workers and pharmacists, have increased and are funded by practices or Midlands Health Network (MHN).

Average GP to patient ratio Urban and rural combined

As a measure of actual GP workload these ratios have limitations. Factors such as size of primary health care team and access to other health professionals are important considerations.

There was no significant difference between most rural and urban practices, although Taranaki rural practices had one of the highest ratios, just below the Lakes DHB average ratio.



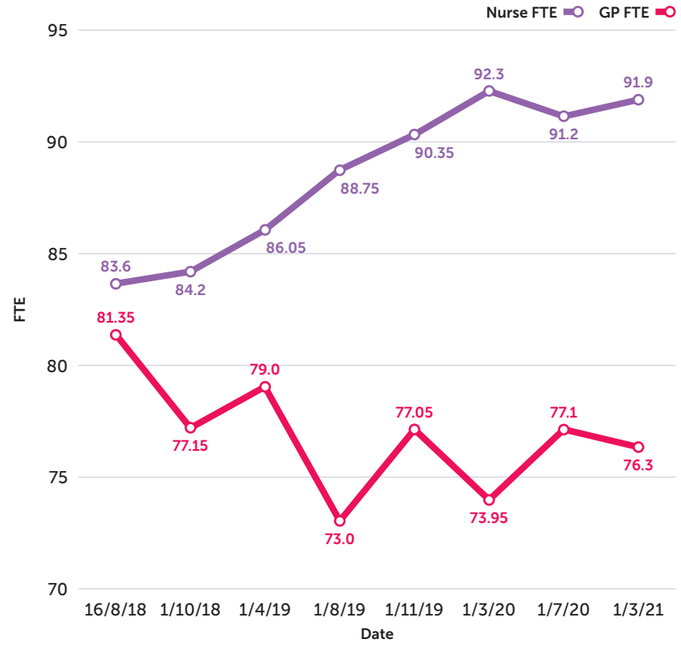
GP and practice nurse trends

Rural workforce FTE

The national trend of increasing difficulty in recruiting and retaining a rural GP workforce is highlighted by our rural workforce trends.

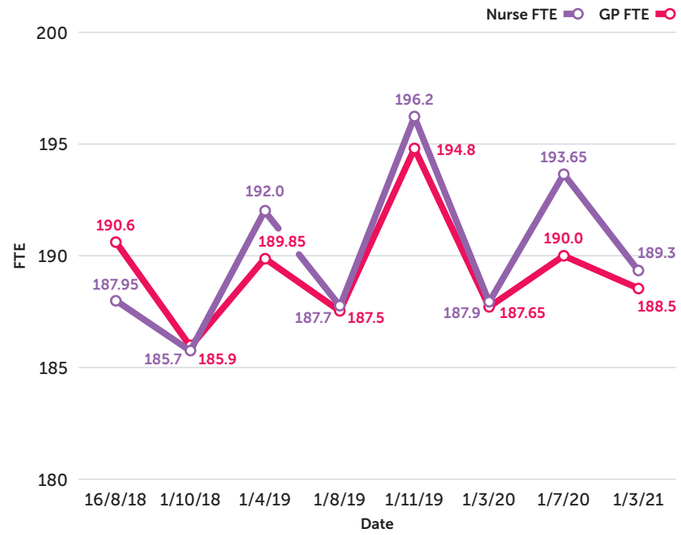
New models of care with an increase in nursing capacity, together with building an extended primary health care team, is key to our rural workforce strategy.

Data in the table on the right shows the increase in practice nursing FTE for the year, alongside decreasing GP capacity.



Urban workforce FTE

Our urban workforce capacity has remained relatively stable, due to recruitment for urban towns being easier than rural communities.



Practice activity

Our practices spent much of the last year focused on catch up and recovery from COVID-19 restrictions. This included a continued increase in the delivery of care via remote methods for those people who chose it, and for whom it was clinically safe.

Our health care home practices were well positioned to continue the remote care that became business as usual. A few practices piloted the use of remote monitoring devices for their COVID-19 and more frail patients, and we continue to support this initiative.

Zoom became a well-established mode for business, clinical and practice support meetings and ensured connection across the network was sustained.

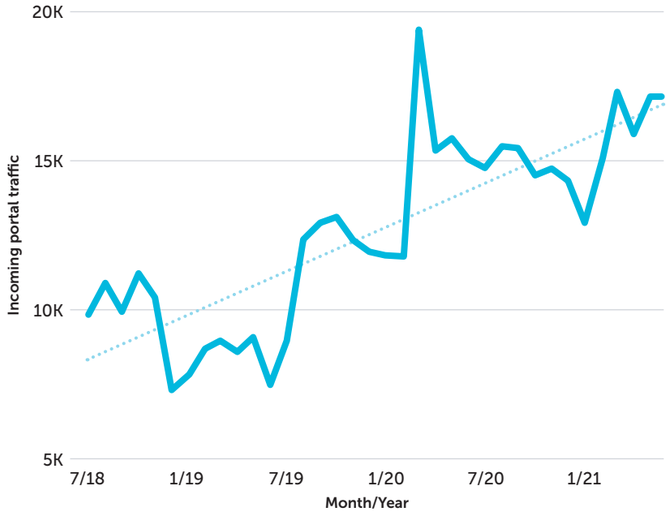
We have been mindful that general team fatigue with the continuation of COVID-19 management has meant limited capacity to progress new models of care or projects in practices.

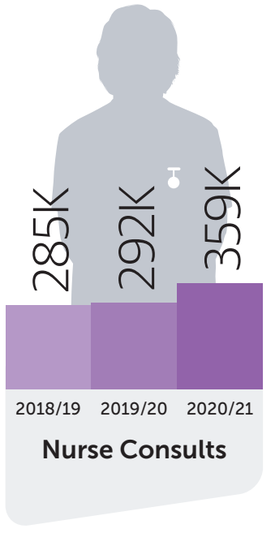
When looking at the stable GP and practice nurse FTE numbers for the last three years, alongside indicators such as consultation trends and incoming portal traffic, we can see that practices are delivering more activity with the same resource. In our rural practices, fewer GPs have delivered more activity in this year, compared to 2018–19.

We also saw an increase in electronic referrals, immunisations, and primary options workload, the latter due to COVID-19 swabbing volumes.

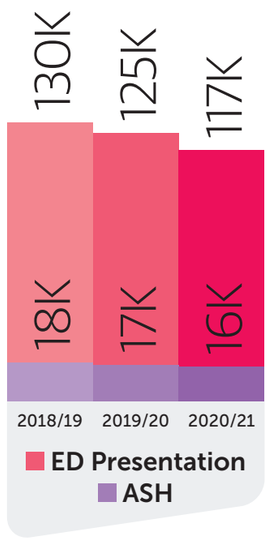
It is pleasing to see the hard work of our network has reduced ED (emergency department) and ASH (ambulatory sensitive hospitalisations) presentations this year when compared to pre-COVID-19 times of 2018–19.

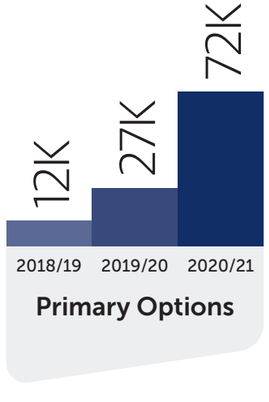
Inward-bound portal activity to practices

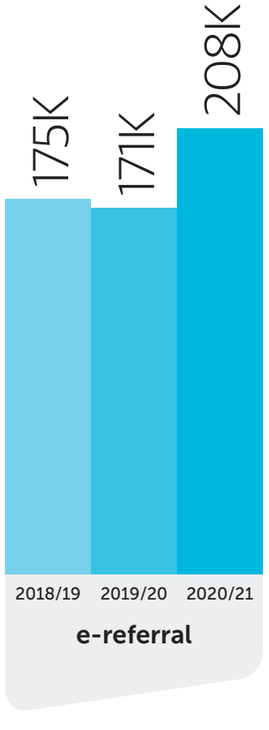


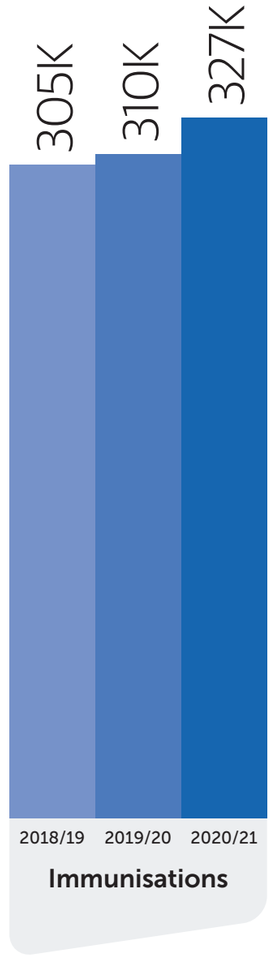


Practice network trends









Network snapshots

3.7M
medications prescribed

1.4M
prescriptions issued

208K
e-referrals made

152K
vaccinations administered

858K
measurements taken

328K
diagnoses made

203K
portal messages received

73K
primary options claims processed

119K
patients triaged by phone

40.7K
COVID-19 swabs taken

1.8M
consults provided

12.8K
children seen after hours

System level measures

Childhood immunisations

During the 2020–21 year, Pinnacle practices achieved 78 per cent of child immunisations at 8 months, and 80 per cent at 24 months.

While our performance was on par with the overall New Zealand performance, we still recognise there is room for improvement, especially in relation to our Māori population.

Tamariki Māori immunisations at 8 months and 24 months

	NZ AVERAGE	PINNACLE MHN
8 months	77%	78%
24 months	79%	80%

Pinnacle localities for all children compared to the DHB total

	LAKES DHB	MHN—LAKES
All	79%	82%
NZ European	88%	92%
Māori	72%	70%

	TAIRĀWHITI DHB	MHN—TAIRĀWHITI
All	83%	86%
NZ European	91%	92%
Māori	78%	80%

	TARANAKI DHB	MHN—TARANAKI
All	84%	87%
NZ European	88%	90%
Māori	72%	77%

	WAIKATO DHB	MHN—WAIKATO
All	85%	89%
NZ European	89%	92%
Māori	74%	80%

Cervical screening

Cervical screening is one of the national health indicators, and in the 2020–21 year all four of our localities achieved over 80 per cent in cervical screening of NZ European women.

However, with only 50 per cent of Māori women attending cervical screening, our performance highlights the work still required to close this unacceptable equity gap.

We have a dedicated Māori team who support wāhine to appointments, run various community-based screening sessions and follow up those who are overdue a screen. In partnership with our Māori health providers and iwi we will continue to make this a high priority.

Cervical screening rates

	LAKES	TAIRĀWHITI	TARANAKI	WAIKATO
NZ European	80%	83%	82%	81%
Māori	46%	49%	53%	51%

Eligible patients with a CVRA

	LAKES	TAIRĀWHITI	TARANAKI	WAIKATO
All	79%	86%	84%	87%
High needs	71%	85%	83%	87%

CVD triple-therapy

	LAKES	TAIRĀWHITI	TARANAKI	WAIKATO
All	36%	43%	45%	43%
Māori	32%	46%	45%	41%

Smoking brief advice

The Government has set a long-term goal of reducing smoking prevalence and tobacco availability to minimal levels, making New Zealand essentially a smokefree nation by 2025.

We want to support all smokers to quit, given the high level of lung cancer disease. Our practices and brief advice team provide support to those who wish to do so. We have some way to go to achieve our target, and we continue to make this a priority.

Smokers receiving brief advice

	LAKES	TAIRĀWHITI	TARANAKI	WAIKATO
All	64%	71%	76%	87%
High needs	61%	70%	73%	87%
NZ European	66%	75%	77%	86%
Māori	59%	68%	67%	83%

Diabetes

The national diabetes quality target is for a blood sugar level, measured as % HBA1C, to be less than 64mmol/mol.

HBA1C is a measure of how much sugar has soaked into red blood cells. A percentage greater than 64mmol/l is linked with worse outcomes for people with diabetes.

Not everyone will be able to keep their sugar levels well controlled, but we try to help everyone keep this measure as low as possible.

Diabetics with blood sugar levels below 64mmol/l

	LAKES	TAIRĀWHITI	TARANAKI	WAIKATO
All	62%	59%	67%	67%
High needs	55%	56%	61%	60%

Health equity: Service development

Delivery on our strategy for improving Māori health equity this year included a specific focus on internal tikanga, service and data development. The ongoing development of Te Taumata Hauora, chaired by Gary Thompson, has been significant in guiding our work in this area.

Across all our localities we have examples of our network working with iwi and kaupapa Māori providers to improve our contribution to better health outcomes, and how we measure those within a system-wide whānau ora framework.

One of these examples is the work undertaken by our digital team to create equity data tools for MHN and our practices that enable data-informed awareness and service responses. This has enabled us to have an objective view as to where our inequities lie, especially for key health indicators.

100%

innovation funding targeted to Māori health

33%

Extended Care Team consults are with Māori

50%

LTC quality plan targeted to Māori health and high needs

Case Study

Lakes: Tāne Takitu Ake ki Taupō

Te ao Māori and use of Te Whare Tapa Whā underpin Tāne Takitu Ake ki Taupō, a special programme that supports tāne Māori with long-term conditions to make major health and wellbeing improvements.

The name of the group was gifted to the Taupō extended primary care team by the original Tāne Takitu Ake group in Rotorua. They also provided āwhina to Taupō programme co-leader and kaiarahi (peer support worker), Shane Rakei.

Shane is a previous client of the Taupō team who made incredible life changes working with the service. He now supports other tāne on their journey, sharing his story and providing connection through kaupapa Māori using waiata, puoro, te reo, rakau and a haka written and developed by tāne in the programme, composed by Hamu Lacey and Tracey Ormsby. Tailored learning and support comes from health coach practitioners, dietitian sessions, group exercise and medication support. Budgeting services and social work also feature.

One tāne referred to Tāne Takitu Ake ki Taupō had been in Rotorua Hospital for pneumonia and fluid on the lungs. He had an irregular heartbeat and low blood pressure. He worked out changes to his medication regime with the Pinnacle clinical pharmacist, and began exercise sessions in the pool with the group. Supported by Shane, he also went to a marae clinic for smoking cessation advice, eventually cutting back to one a day.

At the end of the programme the tāne said he felt healthier and better equipped to contribute to an improved whānau environment. "It gave me my life back."

Building close connections and trusted relationships with both with tāne and the wider community is a strength of Tāne Takitu Ake ki Taupō. Referrals are coming in from general practice, local health providers, and Tuwharetoa Health (the local Māori health provider). Māori settlement trust Te Pae o Waimihia gifted ongoing funding that is being used to establish noho marae at the start and end of future cohorts. It's a programme that will continue to evolve to best meet the needs of tāne in the rohe.

Tairāwhiti: Gisborne barbershop project

Launched in 2019, the Gisborne Barbershop project is a community-facilitated initiative aimed at increasing engagement and health literacy in men who do not typically access primary care.

The Turanga Health pilot programme, supported with Pinnacle funding, trained barbers to create an environment where men feel comfortable having health-related conversations and engaging with primary care services.

Barbershops were planned to be the setting for the project, but significant disruptions from COVID-19 meant many men cut their hair at home instead. With this learning, the project evolved to enlist barbers at the Turanga Health Elgin hub.

Following the success of the barber shop project and feedback from tāne, Turanga Health has launched and is running the following initiatives from the Puna Ora hub in Elgin:

- Elgin Community Ukulele Club (held weekly with up to 30 participants).
- Walk-in meth evening (held weekly with up to six participants).
- Foetal Alcohol Syndrome Group (held monthly with up to 10 participants).
- Ministry of Social Development co-location with Turanga Health.

Case Study

Taranaki: Parihaka clinic

LEFT TO RIGHT: Alex Neil, primary care practice assistant; Rachel King, member of the Parihaka Papakinga Trust; Kiri Wicksteed, lead doctor for the clinic.

Whakaihu Taiora is a marae-based medical clinic offering free services to Parihaka residents and the wider community.

Launched in November 2020, it's the result of a responsive co-design process between the Parihaka Papakāinga Trust, doctors from local Opunake Medical Centre, Taranaki DHB and Pinnacle.

The kaupapa of Whakaihu Taiora is to provide healthcare centred in Māori culture, based in a place whānau know well and can access easily. Traditional 15-minute appointments common in Western medicine don't feature here. Instead, whānau might see the GP and nurse from Opunake Medical Centre for an hour or more, an organic approach that is responsive to the needs of the remote community it serves.

Case Study

Primary care nursing

7
new community nurse prescribers

4
practices hosted the first-year Bachelor of Nursing students

4
new graduate nurses into NeTP programme

58
nurses enrolled on prescribing course

70
attendees at nurse leadership series

65
nurses attended the inaugural Pinnacle conference

Launch of the annual Pinnacle nursing scholarship

2020 global Nightingale Challenge lectures delivered

Wintec master contract for student nurse and Master of Nursing students' practice placements

MHN nurse leads appointed as clinical academic partners to BN programme

Profile: Nursing scholarship

Huia Brady, a practice nurse with Tui Ora Family Health was the recipient of Pinnacle's 2020 Practice Nurse Scholarship for Project Whero, a proposal for a nurse-led community clinic in the township of Waitara, Taranaki.

> "I think it's a privileged position to work with whānau in primary care. Being able to have a korero with someone when they're in a vulnerable state, when you might have only just met them."

The Tui Ora practice team had identified the need for a satellite clinic in Waitara, a district where people experience high levels of deprivation and associated health inequities and challenges. Twenty per cent of Tui Ora's patients live in Waitara and many were finding it extremely difficult to get to New Plymouth—a trip that requires three bus rides and a walk.

> "I have a big drive to decrease inequalities in health care that are out there for people. I was super excited when I heard about receiving the scholarship; it means we can make the clinic happen."

Project Whero aims to make health services more accessible and affordable, reducing deprivation barriers and increasing health and wellbeing for Waitara patients.

Huia will be sharing the outcomes and learning from the project at our 2021 nursing conference.

Network engagement

Our extensive network of practices across the four localities has meant engagement among teams has been essential.

The importance of this communication and peer support saw engagement increase this year, through initiatives including membership clusters, online leadership training, and active participation in the national Health Care Home Collaborative. This was especially pleasing given the workload and fatigue of practice teams.

Membership clusters

The engagement of Pinnacle Incorporated GPs has been both positive and productive. A key objective of the clusters was to bring Pinnacle Incorporated activity and decision-making closer to the members and improve communication both ways.

Members shaped the quality plan for the last year, discussed and agreed to keep membership to GPs at the present time, and influenced developments in their own localities. The clusters have evolved, with some merging.

Practice development, Health Care Home and support

Using internal HR expertise, Pinnacle developed and facilitated online leadership and management training targeted to practice managers and lead administrators. This online workshop series was well-attended with 12–20 participants at each of the three sessions from across the network.

30 practices engaged in strategic business planning and Health Care Home workshops for owners and practice managers. Seven of these practices progressed to a bespoke owner workshop. The principles and our rich learning from embedding a Health Care Home model of care continues, but within the wider context of future business and service planning. This led to strategic changes including the appointment of clinical pharmacists, growth through acquisition and service diversification.

This year we have continued to be an active member and contributor to the national Health Care Home Collaborative.

31%

membership attendance

104

members attended at least one meeting from June 2020–June 2021

Case Study

Taupō Medical: Health Care Home Clinical Teams

Facing an ageing New Zealand GP workforce, a growing population and increasing patient expectations, the team at Taupō Medical knew they needed to do something different.

Working within the Healthcare Home model, they are in the process of developing a unique clinical delivery solution using clinical teams.

Patients at Taupō's largest practice are assigned a team instead of a specific clinician. Each team is made up of one or two GPs, a nurse practitioner, a nurse and a medical clinical assistant (MCA). The GPs work as consultants, ensuring high standards of care, dealing directly with the more challenging cases, and working with the nurse practitioners and nurses to provide timely delivery of healthcare. MCAs manage patient flow and collect initial patient health data.

Executive chairman, Dr Dale Towers, says it's a model that offers sustainability to practices; more interesting and challenging medicine for clinicians; and more timely and effective healthcare for patients.

"We are acutely aware that attracting both experienced and trainee doctors is getting harder," says Dale. "The 15-minute appointment model means clinicians are not always challenged to work at the top of their scope. The clinical team model offers GPs a more specialist role within the wider clinical team."

Taupō Medical currently has three teams serving nearly 17,000 patients. Dr Towers says that using the team approach, combined with a high level of virtual consults, has seen patient wait times for routine appointments reduce from up to three weeks, to just a few days.

The clinical team structure is still in the early stages of development, with longer-term plans including the addition of a clinical pharmacist and a wider range of health services.

Strengthening rural healthcare

As per our strategy, we have strengthened rural primary care in a number of areas.

- 22 rural GPs received training and equipment to provide practice-based ultrasound. More than 1,000 scans were undertaken to support diagnosis and pathways of care.
- Work done this year released Waikato flexible funding for new practice-based roles in rural practices. These include mental health practitioners, nursing, kaiawhina, dieticians and clinical pharmacists.
- We provided holiday locum cover for eight rural practices with high seasonal demand.
- We undertook a telehealth monitoring trial. This involved two practices and 25 COPD/CCF patients over a six-month period. There were 1,646 in-hours contacts and 716 after hours contacts with the telemonitoring service. 95 per cent of participants felt the service improved the self-management of their condition and were confident in the programme.
- All practices now have access to fibre-like speed broadband services, enabling full access to internet-based services, for themselves and their patients.

22

rural GPs received ultrasound training

100%

of practices have access to fibre-like speed broadband

Rural healthcare embraces POCUS diagnostic tool

In September 2020 Pinnacle funded the use of Butterfly IQ ultrasound devices, along with training, in rural practices, as part of its rural strategy to invest in technologies that enhance services for patients.

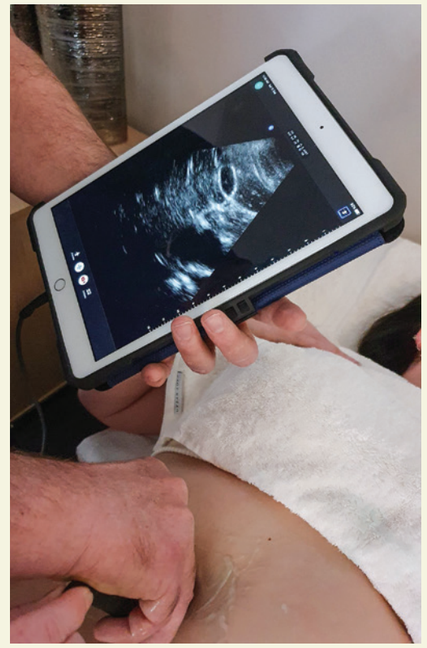
Thames Medical Centre GP Dr Kerry Hennessy is one of the rural clinicians who has embraced the training and technology for Point of Care Ultrasound (POCUS), and seen the benefits.

Located 1.5 hours away from Waikato Hospital, with limited access to ultrasound services and many patients aged over 65 years, he says POCUS has been particularly useful to detect tumours, heart failure and aortic aneurysms, DVTs and other vascular presentations.

"Since we've been using the ultrasound we've located one ovarian tumour, an aortic aneurysm, valve problems, a renal tumour," Kerry says. "We haven't launched into the lung side of things much yet, but these machines are brilliant for looking at the state of people's lungs—especially relevant for COVID-19."

He took the Butterfly IQ to a recent call out to a local resthome, to determine whether a patient needed a catheter. The situation was resolved quickly, avoiding a long ambulance ride and lengthier wait at hospital. Nurses in the Thames practice are also interested in learning to use ultrasound for musculoskeletal work, IV access and other applications.

"I'm delighted Pinnacle is introducing ultrasound, with Bryan MacLeod and Michael Miller taking such active roles," says Kerry. "It is changing the diagnostic model—we'll be more likely to use ultrasound than a stethoscope in the future. This is really just the beginning."



"It is changing the diagnostic model—we'll be more likely to use ultrasound than a stethoscope in the future. This is really just the beginning."

Case Study

Regional services: Innovation and performance

The Extended Primary Care Team Model

Developing extended primary care teams that integrate and complement general practice services has been a high priority.

We now have well established teams in Taranaki, Lakes and Tairāwhiti and integration with practices and local providers is strengthening. The team delivers individual consultations as well as a significant number of team-based group consults.

4,387
total individual consults

33%
consults with Māori

2,424
dietitian consults

898
social worker consults

245
exercise co-ordinator consults

113
hauroa kaimahi consults

318
clinical pharmacist consults

Multidisciplinary approach to complex needs

In May 2020, Patricia was living in an emergency housing motel. She was highly stressed with poorly controlled diabetes, experiencing side effects from different medications and struggling to access social support.

A referral to the Tairāwhiti extended primary care team gave Patricia access to the multi-disciplinary support she needed.

Combining the skills and knowledge of a primary care pharmacist, social worker, clinical nurse specialist (diabetes), cardiac pulmonary nurse co-ordinator, kaiawhina, and a nurse focused on smoking cessation and child health, the team takes a collaborative approach to better support people with complex health and wellbeing needs.

Patricia was initially referred to social worker, Lana, who quickly involved clinical nurse specialist, Kim, and primary care pharmacist, Dianna.

"Lana came first and went with me to WINZ to help with the process of finding a home," says Patricia. "She also sorted out my disability allowance. Kim got me a sensor for my diabetes, to check my sugar levels, and reduced my insulin. Dianna suggested a change to one of my medications."

Now living in a council flat with her benefits organised, a FreeStyle Libre to constantly monitor her blood sugars, and her diabetes and medication under control, Patricia is managing well and feels really happy. "I'm doing well, I really am," she says. "They are all so excellent, do their jobs well and don't judge anything. I'm so grateful."

"Kim got me a sensor for my diabetes, to check my sugar levels, and reduced my insulin. Dianna suggested a change to one of my medications."

Case Study

Our impact: Three stories from the Taranaki Extended Primary Care Team

Michael's story: Working towards health goals

In August 2020, Michael was referred to the Taranaki extended primary care team. The 68-year old was struggling with his weight, and it was affecting his diabetes, COPD, cardiac issues, and sleep apnoea. Dietitian, Hannah, called Michael and went to visit him and his wife at their home.

"My wife is not well, I was struggling in a lot of ways, because of my weight. It was good to have nice people come have a chat—it all built up from there," says Michael. Hannah was soon joined by primary care pharmacist, Fran, Hauora Kaimahi, Matire, and social worker, Hannah.

"Hannah the dietitian went through what food is good and what's not. Matire came over and helped me with meals, got me on the move. Fran talked to me about my medications," says Michael.

"Hannah the social worker went through everything with WINZ and got me started on the exercycle. She also talked me into putting my name down for a council flat."

Michael and his wife now have home-based help, increased financial support from WINZ, and ongoing support from the team to help Michael work towards his health goals. "They've been absolutely fantastic. They just make you feel so welcome. I can't speak highly enough of them—they've helped us so much."

"My wife is not well, I was struggling in a lot of ways, because of my weight. It was good to have nice people come have a chat—it all built up from there."

Taranaki extended primary care team social worker, Hannah, with a patient

Carole's story: Finding an experienced network

In November 2020, Carole was suffering from health conditions that left her unable to drive. Over the past few years she'd had negative experiences with the health system, being referred to different departments and services.

Feeling overwhelmed, misunderstood, and vulnerable, she was sceptical when her GP referred her to the Taranaki extended primary care team.

Hannah, the team's senior social worker, acted as Carole's primary contact and rallied a team of professionals around her—a dietitian for her diabetes, primary care pharmacist for medication support, as well as mobility and spiritual support. All visited Carole in the comfort of her home.

"Pinnacle has come through. They were hands on and realistic. Everyone in the team had their experience and specialist field—that's what I liked, the complete entire network. We have accomplished so much with all of them together. They have gone over and beyond," says Carole.

When her housing situation became unsuitable, the team's hauora kaimahi, Matire, took Carole out to look at houses, and helped her avoid emergency housing. She recently moved into a new home. "This is what people need," says Carole. "That one point of contact, with teams branching out that have everything you need. That network."

"Pinnacle has come through. They were hands on and realistic. Everyone in the team had their experience and specialist field—that's what I liked, the complete entire network."

Catherine's story: Turning things around

Catherine was struggling with the effects of obesity—serious cardiac and respiratory issues, diabetes, social anxiety and accompanying isolation. She was referred to see Micah, a dietitian in the Taranaki Extended primary care team.

"Micah came to me at home, which was great. We went through portion sizes, what I was eating, and turned things around," says Catherine. Along with diabetes education, she also met with primary care pharmacist Fran about her medication, and started attending a local gym with support from social worker Hannah.

"I'm so happy with the support I've had," says Catherine. "I want to build up to a few more days at the gym. My goal is bariatric treatment, so keeping my diet on track and medication doing what it's supposed to, will help me get to the next step."

Socially, hauora kaimahi Matire connected Catherine with a women's knitting group, and Hannah encouraged her to join a group with others who are big that the Taranaki Extended primary care team were offering to support people they were working with.

"Five of us meet regularly and have speakers from different places, we call the group 'Large as Life'," says Catherine. "It is just amazing to find other people that are in the same boat and have walked the same story. You feel like a little family."

"Basically it's been a complete 180 in my life. It's definitely important that people know: if you need a hand, it's available. It's not really as scary as you would think it would be!"

"Basically it's been a complete 180 in my life. It's definitely important that people know: if you need a hand, it's available. It's not really as scary as you would think it would be!"

School-based Health Services Decile 1–5 schools, Waikato

Our team of 30 nurses and 20 GPs provide services to 12,500 youth across 36 facilities including high schools and kura kaupapa.

14,189
Consults for the entire service

48%
Māori students accessing the service

4,234
4,234 individual students visited (over 1 in 3 students)

11,379
Nurse consults

2,810
GP consults

1,531
HEeADSSS assessments (74% of target population)

11
pregnancies for the entire service (national average for this size population would be 162).

Alternative education school services

Nurse practitioner Karen Thurston has seen many transformations in her five years supporting the He Puāwai teen parent unit and other alternative education sites across the Waikato.

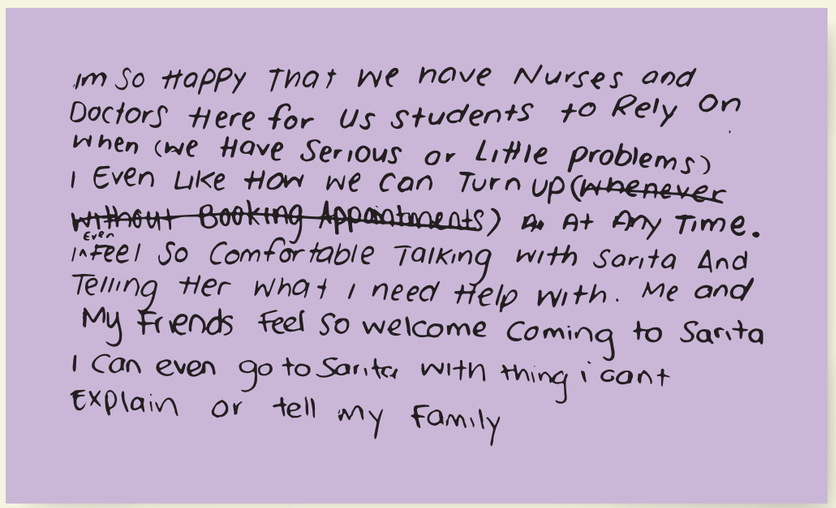
"I just love the work we do, it is such a privilege to work with these young people."

One of the highlights this year was the robust wraparound support created for a student at one of her sites. The student had a significant head injury and was experiencing memory loss and difficulty with mobility, alongside previous long-term trauma and mental health issues. Their ACC support wasn't working and they didn't have a GP.

Karen supported the student to manage their medication and got whānau on board with day-to-day support. A psychologist, occupational therapist, and physiotherapist were organised to come on site, making use of the school gym to help with mobilisation. "It has been amazing," says Karen. "The student's health literacy has improved, they've got more confidence. The plan is to integrate back into primary health care as they transition out of alternative education. In another year they'll be there."

Case Study

Rangatahi feedback—school clinic service



Te Tumu Waiora / Te Manawanui Primary care mental health, Waikato and Taranaki

3,845
consults completed

24%
Māori people accessing the service

2021
This year saw the expansion of the programme to Taranaki.

10.8
Health Improvement Practitioners

59%
people seen same day

9/10
client helpfulness rating

"What we've got here is working so well. The whole practice is behind them [the HIPs and Kaitautoko]. We feel so lucky to have them. The GPs love they can say "Here meet xxx and they do their thing..."

Tui Ora administration manager

Grace Monk
Health Improvement Practitioner
Taranaki

I had a warm handover/HIP session at Tui Ora with an 83-year-old lady. The GP stated the presenting problem was anxiety and worries about getting dementia, as her older sister has experienced fast progressing dementia.

We completed a health assessment and began with discussing life context. It turned out her worry was about something completely different. She had no one to talk to about the friendship she had rebuilt with her first ever partner from when she was 16 years old. They had reconnected over the last four years and she didn't know how to bring it up with anyone. She wasn't sure if their friendship would be understood by her family.

She created a really great plan around putting up boundaries for herself and understanding the value of friendships/human connection.

I had a five-minute follow up session the following week with her, where she said she felt completely different after having a HIP session. She has begun participating in the activities at her rest home and is now enjoying the time she is getting to spend with others, as previously she had begun to isolate herself. The opportunity for a HIP session changed the way she was viewing the stresses in her life, which was incredible. She gave an overall 10/10 for both confidence and helpfulness and was reminded of the HIP service if she ever needed it in the future.

This gave me warm fuzzies! This is just one of many examples but stands out for me because I watched her self-confidence and worth change in a week, which was amazing to see. I love my job!

Our Pinnacle Inc. workforce

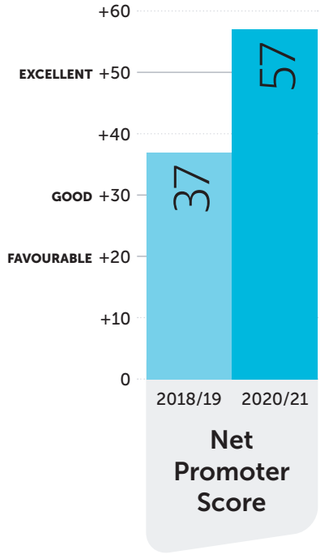
The diversity, equity and wellbeing of our workforce is hugely important to us and whilst there is still work to do, we have made significant progress.

Would our staff promote Pinnacle as a place to work?

- A net promoter score indicates the extent to which employees would promote an organisation as a good place to work (above 20 is favourable, 20–50 is good and above 50 is excellent). Our score for this year was +57, a rise of 20 from 2018–19.
- Supporting staff wellbeing was a key focus during the past year. A new working-from-home policy was introduced, and people work more flexibly to accommodate their individual circumstances.
- Wellbeing vouchers were given to staff to choose a wellbeing initiative that would make the most impact for them. The decision to invest in individualised staff benefits in lieu of a standardised approach was overwhelmingly appreciated by staff.
- Our staff conference in June was well-attended and well-received.

3.3
years is our average length of service

18.4%
total staff turnover July 2020–June 2021



Net Promoter Score

Using our cultural competency framework as a guide, Pinnacle conducted its first cultural confidence self-assessment.

Our cultural confidence journey

The data was used to inform how we could further support staff with whanaungatanga, manaakitanga, kotahitanga and te reo Māori.

A range of initiatives are underway that have had a tangible positive impact, such as an inaugural whaikōrero wānanga and training in te reo Māori.

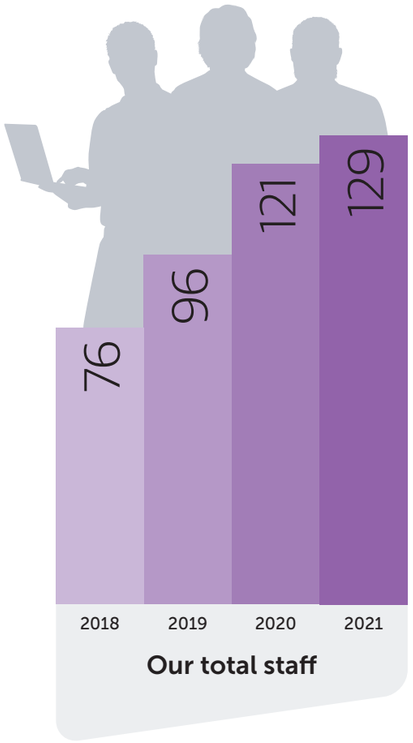
Pinnacle signed up to the Manavation Academy and staff use this to increase their te reo vocabulary. To understand the history of Aotearoa, staff have participated in an historical waka experience and visited key sites of significance across the localities.

Developing leadership

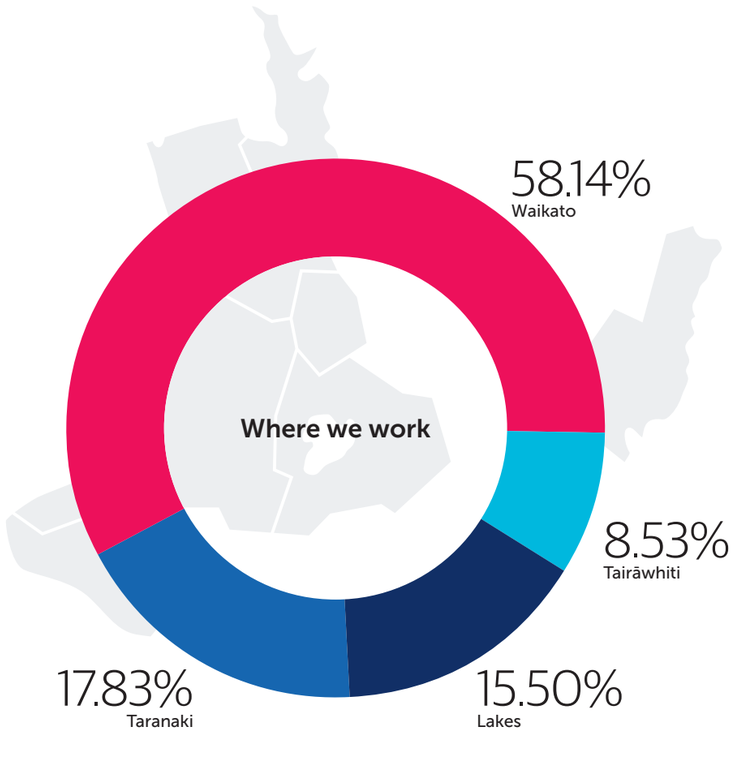
All managers completed a tailor-made leadership course to develop their coaching skills.

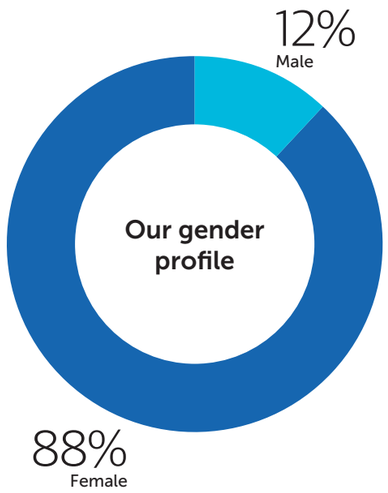
Pinnacle HR also designed and delivered a 12 session online in-house leadership and management series focused on leading self, meaningful conversations, leading others, and managing a team. The first two topics were offered to all staff while the latter two were offered exclusively to leads. There was active participation of up to 20 staff in each session.

Workforce overview



Our total staff





12

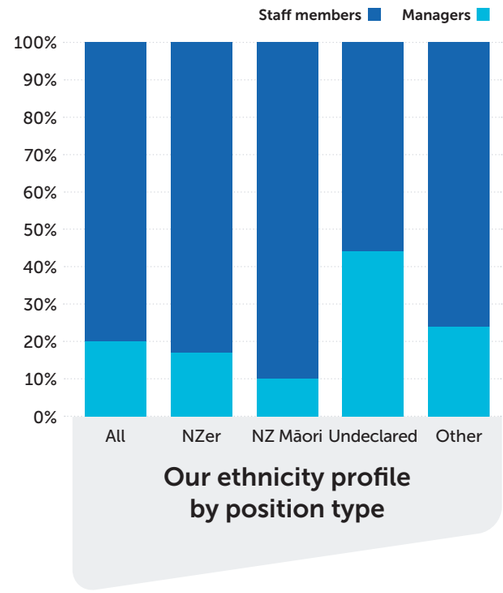
staff took new roles within the organisation as part of their career development plan

99%

smoke and vape free workforce

1

protected disclosure. This serious concern was investigated, actioned, and closed

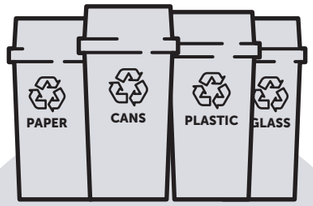


Supporting a greener environment

2020–21 was the first year where Pinnacle purposefully aimed to reduce the impact of our work on the environment.

Our aim is to:

- embed sustainability into our organisational culture, showing our value of kaitiakitanga (stewardship): caring for and protecting our resources
- reduce our landfill waste and our travel-related carbon footprint.



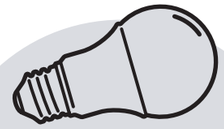
All offices now have improved options for recycling, which includes options for paper, cans, plastic and glass. Extra initiatives, which recycle and fundraise at the same time, have been implemented with some excellent causes supported. Staff bring in items such as bread tags, pens, and lids from milk and wine bottles (not otherwise accepted in mainstream recycling) and see good stuff happen!

We have initiatives, such as keep cup and plate stations to help staff avoid takeaway coffee cups and single use plastic food containers. In our Hamilton office we will be trialling milk in glass bottles, delivered by a Raglan-based organic creamery that already comes to the building. Biodegradable cups are used beside the patient water coolers in Tairāwhiti. We're also switching out consumables items such as tissues, paper, soap and other cleaning products for environmentally friendly options. This includes using bulk/refill options to reduce packaging.

Staff are getting involved in the community, participating in initiatives such as gully restoration or planned clean up days. These occurred on the beach in Taranaki and at Lake Taupō.

E-bikes have been offered to all offices that wish to use one. Carpooling systems are being created locally, and walking to meetings is encouraged. We're also actively monitoring movement between offices to avoid courier travel miles for moving goods around the network. Excitingly, our first hybrid cars are set to be trialled in the fleet, with the first car arriving in September 2021.

We reduced work flights by 48% compared to 2017–18



As lightbulbs need replacing the switch is made to more energy efficient LED bulbs. Air conditioning filters are being cleaned more regularly in Taupō to reduce power consumption.

Paper use is under the spotlight. Work is underway to reduce office printing and replace spiral bound notebooks for fully recyclable options.

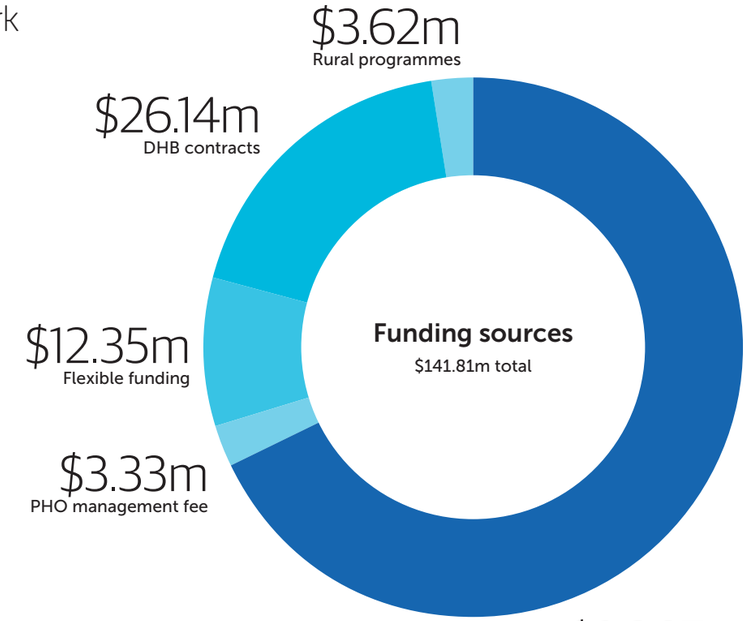
We've reduced the use of bin liners, polystyrene boxes are returned to suppliers, and we've found new lives for the pallets that items such as NRT is delivered on. Food scraps are being taken by staff for composting or feeding hungry chooks and pigs.

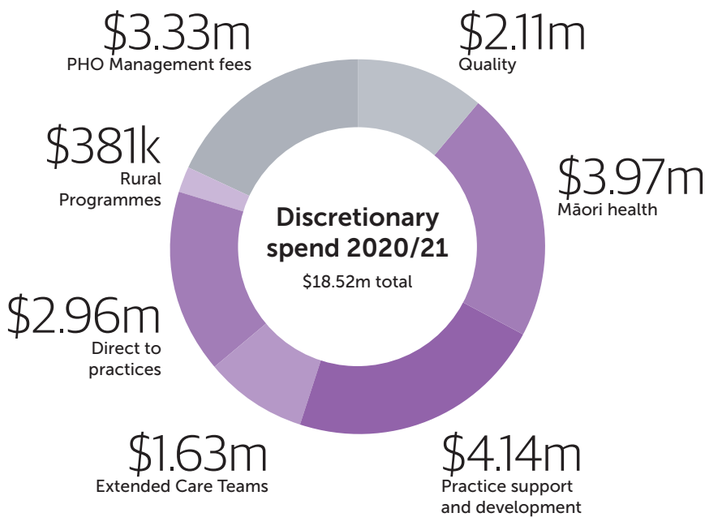
More vegetarian options are on the menu for catered meetings. Reducing meat consumption leads to a reduction of greenhouse gas emissions and decreased pressure on land and water use.

How we distributed our funding

The distribution of our discretionary funding should reflect our strategic priorities, specifically with regard to Māori health, network support and rural healthcare.

We are the only PHO to support our practices in facility improvement and development. This year $287,000 was awarded in facility grants.





Hamilton (Head Office)
Level 3 Norris Ward
McKinnon House
711 Victoria Street
PO Box 983
Hamilton 3204
P: 07 839 2888 | F: 07 863 4102
E: info@pinnacle.health.nz

pinnacle.co.nz