

Collaborative approaches in Primary Health Care

ONLINE SURVEY RESPONSES



A compilation of respondents' feedback

*Exploring ways non-profit NGOs help New Zealanders become healthier
by using their relationships, connections
and innovative models of care
– and what gets in the way.*

**A report prepared on behalf of the
Health and Disability NGO Working Group**

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Acknowledgements and Disclaimer

This report features a range of contributions from many individuals and organisations throughout New Zealand. It is a compilation of perspectives and does not necessarily represent the views of any individual members of the Health and Disability NGO Working Group, their parent organisations, or any other organisations or individuals mentioned in this report.

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Online surveys were conducted from 18 July to 23 August 2011.

This report was compiled by the NGO Secretariat, Grant Aldridge on behalf of the Health and Disability NGO Working Group.

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The size of words represents their frequency in this report. Wordle graphics appear in each section of this report to identify words most commonly used in responses.

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Introduction

The NGO sector is a major provider of public and personal primary health care in New Zealand. Its expertise and community reach ideally position it to assist the government to achieve better health outcomes for New Zealanders.

Non-government organisations (NGOs) receive significant funding (in the order of \$2 billion to \$4 billion per year [approximately 25% of the overall non-departmental health operating budget of \$12.8 billion]) from the Ministry of Health and district health boards¹. The majority are non-profit – providing services to consumers and valuable contact at community level.

Health purchasing changes in the 1990s, aimed at improving competition and choice, led to a proliferation of providers. The NGO sector grew in response to complex needs of key population groups and to government policies and funding models. The introduction of primary health organisations (PHOs) in 2001 added further complexity. The sector is now at a crossroads, as government reforms aim to add value and efficiency at a time of burgeoning health and disability spend.

Greater co-ordination between **all** providers will deliver integrated primary health services that improve effectiveness and efficiency across health and disability services.

In July 2011, the Health and Disability NGO Working Group initiated a project to learn more about non-profit NGOs' collaborative approaches to primary health care delivery and to explore their relationships with other health providers.

As part of this project, an online survey sought feedback to help identify common practices and experiences. This report is a compilation of that feedback. It contributes to the final project report, which will feature various case studies and recommendations when published in late 2011/early 2012.

This comment from one respondent sums up the overall flavour of feedback:

We would welcome with open arms the opportunity to work collaboratively with PHOs, GPs and medical centres. Our philosophy is that we each have areas of strength and working together could ensure that more families/people in the community receive a more holistic level of care, as we each contribute our part and work together – as opposed to separately.

¹ Source: [Ministry of Health website](#) – accessed 10 May 2011.

Overview – Insights from online survey

The 364 survey respondents held a broad range of roles in a variety of different types of organisations covering all DHB regions. The majority were non-profit organisations and/or primary health providers, but those from peripheral services also replied and are included to provide a broader picture of interactions and linkages. (A breakdown of respondents is provided in section 3.)

As expected, the levels of collaboration between non-profit NGOs are much higher than those between non-profits and medical centres, or between non-profits and PHOs.

Many of the challenges non-profits face in engaging and collaborating with others are mirrored in the comments from commercial health providers (e.g. pharmacies) and government bodies.

While many factors hindered greater service integration, some attempts to collaborate and communicate with different providers seemed under-developed and ineffective as a consequence.

Relationships with GPs, medical centres and PHOs

It was difficult to identify any particular trends in engagement between PHOs, non-profit NGOs and medical centres across the country or in any particular health fields. The overall responses on this topic are best summed up in this comment from one respondent:

[The] situation is so different for each area, with no pattern as to why one PHO will be proactive and another disinterested. There is not a strong sense across the country that PHOs are actively engaged in the provider contracts – for this to be more equitable will require direction from DHB/Ministry.

Many respondents did not make any distinction between GPs and PHOs, whereas others clearly saw the different roles each has.

Connections between non-profits and GP/medical centres and PHOs are often at the linkage/referral level, rather than more in-depth service co-ordination or integration. Practice nurses are a vital link in generating referrals from GPs.

For every positive comment about PHOs, medical practices and non-profit health providers working together, there were examples where communication and co-operation do not happen. Reasons for this included:

- A lack of time
- Perceived sense of competition
- A lack of understanding of what non-profits could deliver
- An overly clinical approach to wellness and primary health care
- A lot of change in the system – resulting in broken connections and changes of personnel
- Constraints on funding – where criteria seemed to prevent co-operation or new approaches. (In some cases, it was probably a lack of awareness that funding was

available to support new approaches that was the barrier, rather than a lack of funding per se.)

Difficulties engaging with GPs or PHOs were expressed in these ways:

We believe that our role in primary health is not adequately understood.

The familiarity of PHOs with our work varies from excellent to poor.

We have attempted to work with the PHOs, however we have found that they duplicate the functions that are already happening in the community, rather than work with the community. One PHO has set up a diabetes educator, asthma educator, a disabilities co-ordinator etc and all of these are pre-existing in the community and effective, and would have adapted and provided whatever was needed by the PHO, but the PHO has the \$\$ and, with no community interaction, announced their educators.

PHO contact is controlled by them, they often don't respond to our questions. The contact we have is under their terms – usually means we have to be involved in one of their projects, otherwise be punished. No consultation before they initiate programmes.

We would value the opportunity to work with our local PHOs but all attempts to date have not been responded to.

We find it VERY difficult to work with medical centres. Even with face-to-face visits outlining how we can help with the management/education for clients, we receive ZERO referrals from most GPs. We now choose to focus on generating self-referrals. Very, very frustrating.

We have limited interaction with GP medical centres, not from want of trying on our behalf.

We have struggled to establish good working relationships with GPs.

Our observation is that PHOs keep clients within their own systems and GPs don't refer out to community-based experts – even though the service is free to the users and there is absolutely no doubt as to the comprehensive services offered and the quality of expert care and knowledge (confirmed via DHB audits).

Requests for information tend to be one-way, (i.e. from me to the practices, which means that GPs may not always get information that they need because they don't bother to ask.) GPs [are] not always willing to accept information from other health providers to improve the care that a client is getting. GPs usually willing to furnish details requested about clients.

The doctors should have the charge of being a doctor. From what I have seen the changes are not being felt in the community,The PHOs are ending up duplicating much of what has been done already and is in existence already. They should utilise that which exists and support them and if those groups received the funding that the PHOs are getting, then we may have some real community impact as it is people in the community helping people in the community.

External issues and other barriers sometimes get in the way:

We have a problem that we work with a DHB and many different PHOs, and they do not get on – in fact, they are almost competitive with each other. We actually initiated a meeting between two PHOs and all they did was one-upmanship with each other, and no solution was reached regarding our working together.

We often find the definition of health promotion within primary care quite limited. Health promotion is often viewed as education only, and promotion at a population level is commonly interpreted as ‘group education’, so there are not always joint objectives for us to work with primary care. However, we are happy to help wherever possible.

There is a lack of understanding about the role of PHOs and even some provider member GP medical centres struggle to get to grips with PHO changes. In some cases, amalgamation has reduced opportunities for collaboration:

Since the combining of PHOs, we have not had the same amount of contact with them and it appears that small community initiatives no longer happen with NGOs such as us. This is disappointing.

We don't feel we have certainty, status or fairness sometimes.

There has definitely been a loss of respect, trust and perceived level of support since the merger. What was once a welcoming office is now a skeleton of its former self. I have no idea who to call/contact if I have questions, need clinical guidance or support, have suggestions or complaints.

More education about PHOs, who they are, what they do – why they exist, how they differ from other groups – is it merely their funding sources that defines their difference to other NGOs?

People identified a need for more communication from PHOs and DHBs too:

Communicating, collaborating or having any meaningful contact is challenging as it is difficult to understand their structures, hierarchy and who the right person to link with is.

.....there does appear to be a lack of clarity re who is actually providing what, how to access these providers, what their criteria is etc. As a clinician on the ground, this becomes very confusing and often leads to disengagement and a ‘do-it-yourself’ attitude. Greater transparency around these issues would enable services to work better together.

It would be helpful if there were one place we could go to, to communicate with all PHOs at one time.

Many recognise the importance of resourcing and prioritising relationships and collaboration:

A co-ordinator of collaboration is key to our working together effectively, as is the building of relationships.

The PHO-NGO partnership needs to be encouraged and resources invested to help this happen. Many NGOs are now staffed with professional, competent people who deliver an important service in the community. This work has value, needs to be recognised and supported, along with the work done through the PHO.....to work with PHOs some investment would be needed, however this may be less than if the PHO provided this service themselves.

Key relationships are important for getting the best results for our clients and the sector as a whole. Often who you know provides significant leverage in terms of getting results and/or addressing serious client needs promptly.

There is huge value for anyone involved in all help services to learn to network with all NGOs and PHOs in all areas as this can only benefit the consumers.

Future changes we would recommend to PHOs are:

i) nominate and make accessible a person/contact specifically for NGOs to discuss possible collaboration

ii) be willing to work collaboratively including joint applications for funding etc

iii) acknowledge the value of NGO support for patients, particularly in managing chronic health conditions and make referrals sooner rather than later.

Managers insisting these relationships are an important piece and need ongoing work to manage/ maintain.

A main driver of collaboration that does happen seems to be responses to a specific patient need – where an individual or a provider does everything possible to ensure a person or family get the care they deserve.

Few examples of systematic collaborative processes involving non-profit health providers working with PHOs or GPs were given. Examples where the non-profit played an integral part in the collaborative pathway seemed mostly one-off approaches. Where a more systemised collaborative approach was taken around a key health issue (e.g. diabetes), the NGO provider seemed on the periphery or brought in as an addition once ‘the system’ had been established. Given the size and scope of the non-profit health sector’s range of primary health care services, this is not desirable.

The case study examples to be profiled in the second part of this project may show there are places where the broader primary health care sector has recognised the vital contribution non-profit health providers can play in an integrated delivery model.

NGO connections and other relationships

Extensive, wide-reaching networks and connections across health, social services, education etc are evident from analysis of individual responses:

Because we work in management of a chronic condition, this takes a team approach – the more connected the members of the team are, the better supported is the client – similar messages and the valuing of all team roles.

Our relationships and collaboration all has one focus in mind: To assist referrers, providers and all users of the health systems in our region to navigate quickly and efficiently from one service or health professional to another – to ensure timely, appropriate services are put in place for clients.

One relationship that is important to us is with our local DHB. In our situation they provide a small amount of our funding, but they are also a good source of referrals for us – as we are to them. The relationship has evolved to the stage that we are invited to participate in the discussion and development of new initiatives and there is a more collaborative approach being embarked upon, as we recognise that partnership is the way to continue our service provision to a wider range and number of people on a limited budget.

But there are still challenges:

Well-built relationships are breaking down due to restructuring and re-jigging of certain services (such as the community nurse role).

The desire for a more community-based, family-centred model of care is a common theme throughout many comments – emphasising the importance many NGO providers place on building links with social service agencies and other supports beyond pure health services. Comments indicate comprehensive understanding of patient's/consumer's/client's life challenges and broader issues that may compromise their health and/or well-being.

There is no point in expecting many of our patients to come into surgery or clinic – many won't. Even when they do – people can pull themselves together very well for a few minutes. GPs only get to learn of whatever the patient chooses to share with them. By establishing rapport with the patient and family/whānau in their own real messy world, we can identify change and proactively manage these patients – avoiding wasting valuable secondary level resources.

.....for the most part I don't yet see significantly more integrated models of care. What I do see are some specific programmes (e.g. Green Prescription, Smoking Cessation) that are funded by the PHO, but our clients are not asking for those and thus not engaging with them. Yes they realise they are overweight and that smoking is not good for them, but they are too overwhelmed by other life crises (e.g. family violence, other relationship breakdowns, extreme financial stress, urgent housing needs, addictions) to have the energy to get on board with healthier diet and exercise.

Opportunities for extension of a Whānau Ora approach also exist:

Support worker feedback indicates that the primary health care provided by Whānau Ora and Pasific centres are more person-centred and cost effective than services provided by mainstream PHOs.

Making a difference

A wide range of sometimes contradictory suggestions and ideas were identified by respondents, and a read of pages 86 to 107 is recommended, as all the ideas cannot be adequately captured in summary.

The following quotes give a flavour of the issues and suggestions:

Better communications – especially from GPs and their nurses. Openness to other models of care or wellness. Early intervention and communication of that through all the various support networks around that person.

The DHB remains unclear on its strategy to support collaborative and integrative relationships in the primary setting.

Fragmentation of mental health services in Auckland is a big problem – with PHOs, DBHs, A+, contracted NGOs, voluntary sector and private sector all offering services with different funding and criteria – very complex even for people working in the field to navigate and get clients to the right service.

One thing that pushes fragmentation is the funding process.....I have suggested that there is an over-arching body, which could put more rationale into funding decisions to drive better collaboration.....my own view is that there is a lot, and I mean a LOT of money swishing about, but it is poorly directed and not well-used.

The health system is complicated and getting more complicated all the time. Different funding streams, repositories of information, services, criteria, etc, etc. It is impossible for health professionals to be aware or have up-to-date knowledge of all of these factors.

A streamlined way to access information about how we can contribute to other primary health care providers' models of care and support to do this would enhance our ability to work together.

If we had a single liaison person who understood exactly what we could offer and could then help us link into current projects, we would be well-placed to contribute more effectively.

.....need to move to incorporate a stronger psychosocial model into primary health care; particularly for mental health, where social indicators have such a weight on consumer well-being.

[Need] time and resources to really develop good working relationships between agencies, not just individuals.

.....most of the effective collaborative work I have achieved in the community has been because of the enthusiasm and commitment of a handful of key people wanting to make things happen.

I feel much more support and funding needs to be given to the development of advanced nursing roles across all primary care settings.....the current (largely) medical model of service delivery is not going to keep up with the increasing needs – we need to make better use of our GPs, and develop innovative ways of supporting the services they provide.

Removal of the business structures that separate secondary and primary, and a joint way forward with all professional groups included, where the dominant discourse is client and family access and not a medical model.

The \$\$ that are available for primary care could be used much more effectively if less 'red tape' were involved and the need to 'pilot' new services was stopped. When something has proved successful in other areas, I can't see why the whole project plan and pilot needs to be re-developed in each area.

We are limited not by our imagination, drive or ability, but by the financial resource to deliver services.

Shared vision for consumer/client, not for organisation.

Many comments throughout the responses express disappointment and frustration that those involved on the frontline and in the community are not being involved in the planning and discussion of issues as they would like to be. Often their knowledge seemed unappreciated, unacknowledged and unfunded. This is perhaps best summed up by this comment:

Some of the solutions are so bloody basic...and yet apparently so bloody 'invisible' to those who make all the decisions!

Any major differences between sectors?

Interestingly, the challenges that non-profit NGOs face in building collaborative relationships with GPs/medical centres and PHOs, and working within the system generally, were echoed by the government bodies and commercial providers that responded to the survey.

In the main, their responses to various questions mirrored the trends of the wider group. One exception was referral levels to non-profits health providers, where non-profits showed significantly higher levels of referrals to these, than did the commercial or government providers. Government providers received a much larger level of referrals from GPs/medical centres. Commercial providers had initiated contact with PHOs at almost double the average rate, yet did not appear to have stronger relationships/referrals than the average.

The PHO view

A separate online survey was sent to the 32 primary health organisations, but only 11 completed this and sometimes the people doing so were not the most informed about the PHO approach to collaboration.

However, the following comments from PHO responses show much in common with the views in the broader survey....

.....on both the issues:

When planning services to be delivered to identified communities and populations, it will be in the interest of all to get all stakeholders around the table to ensure all parties are able to contribute and work in a smoother flow (collaboratively). Often services are delivered in isolation with little thought on how another service could integrate with the current model or service.

Poor take up of programmes delivered through traditional general practice approaches.

Often the conversation is too focused around funding for a single/narrow issue. Real value comes from contribution to strategic planning.

The weak link sometimes occurs when a relationship has been established and the person resigns – it takes a good 6/12 months before the contact is re-instated.

.....and the solutions:

Having co-ordinated funding streams to minimise duplication.

More flexible funding would help both parties.

Offering flexible funding to other providers when we can make the bureaucracy (usually DHB or MoH) easier for smaller providers.

Flexible funding by DHBs. DHBs not delivering services better provided by NGOs and PHOs.

Audit procedures should catch up with collaborative approach and auditors share information instead of duplicating effort for no added value.

Better co-ordinated care pathways/intervention models that all agencies agree on and commit to.

Common philosophies. Shared values. Strong relationships based on trust, integrity and long-term goals.

Planning services around the clients, with a recognition that this may mean doing things differently with existing funding.

Pleasingly, 89% of PHO respondents had sought NGO input to service planning and direction-setting, with the same level stating that they'd gained real value from this.

A wealth of ideas in the survey comments

Many respondents took the opportunity to share ideas and suggest a raft of changes for health issues – far beyond just working together.

Browsing all the responses in this report (from pages 38-128) is recommended for many working in health – especially in the following areas: Irlen Syndrome, diabetes, asthma, dialysis, cardiovascular disease, stroke, mental health issues, cancer, pharmacy, podiatry, youth health, Māori health and health services for Pacific people or older people.

Survey responses

The online survey was open for contributions from 18 July to 23 August 2011.

Survey links were sent to around 150 NGOs registered to vote for the Health and Disability NGO Working Group, and approximately 1,200 health-related e-mail addresses sourced from the online [Family Services Directory](#).

It was also promoted on [CommunityNet Aotearoa](#) and through the *ComVoices Media Alerts*.

Who participated?

Recipients were encouraged to forward the survey link on to others so, although it was primarily targeted at non-profit health providers, a range of other related providers also completed the survey.

In total 364 survey responses were completed².

Organisation types

The vast majority of respondents (223) were from some kind of non-profit organisation. (Although some did not specify this in question 1, it was evident from their other answers.)

Around 12 percent were some type of government organisation (e.g. DHB), and 10 percent were a business (e.g. general practice, specialist, etc). Their responses are included here to provide a broader perspective on collaborative relationships involving non-profits in primary health care.

Some respondents said they did not provide primary health care services themselves, but their comments indicated that they could play an important role in connecting clients/patients/consumers to services. (In some instances these organisations were better connected than some of the primary health care providers.)

There seemed to be a high level of grassroots feedback about what is happening in local and regional communities; with less than 10 percent of respondents indicating they were from the national office of a national body.

Respondent characteristics

Respondents could complete the survey anonymously, however around half provided some kind of identifying information. This indicates that people in a broad range of roles, from a wide variety of organisations in most regions around the country participated in the survey. Participant organisations covered a wide variety of health issues and target populations, and included consumer-focused support and advocacy groups, which helps to bring a client-focused perspective to the responses.

² A further 105 partial survey responses were received, however respondents only completed the first three questions describing their service, and provided no information about their relationships, so these responses were deleted from the overall results.

1. ABOUT YOUR ORGANISATION – Please tick all that apply			Create Chart	Download
		Response Percent	Response Count	
We are the national office of a national non-profit organisation		8.2%	30	
We are a regional or local branch of a national non-profit organisation		25.5%	93	
We are a regional or local non-profit, which is not part of a national body		27.5%	100	
We are a consumer/client/patient support or advocacy group		19.0%	69	
We are a government agency/department		12.1%	44	
We are a commercial operation/business		10.7%	39	
We are an umbrella group		3.6%	13	
We receive funding from the Ministry of Health		37.9%	138	
We receive funding from at least one District Health Board (DHB)		45.9%	167	
We receive other (ie: non-health) government funding		21.7%	79	
We receive funding from non-government sources (eg: donations, fees for service, grants, etc)		37.1%	135	
If none of the above applies to you, please briefly describe your organisation in the box below Show Responses		10.7%	39	
			answered question	364

Some respondents provided comments about the type of organisation they were.

These included the following³:

- 12 step support group for friends & families of drug addicts.
- 3 practitioners here receive funding from ACC (2 are counsellors, 1 is a physiotherapist). 1 gets funding from the Courts for relationship counselling, and all receive money from WINZ for those on the disability allowance.
- DHB community service.
- District Health Board. (5)
- General practice.
- I am a consultant dermatologist and work part-time at a hospital and part-time in private work.

³ All comments in this report are anonymised.

- I am a private practicing dietitian who employees other dietitians to offer consultancy services.
- I'm not sure which boxes to tick. We are a Māori Health provider.
- Local not-for-profit primary health care provider.
- Māori Health Provider. (2)
- Medical centre at a school. Offer service to 800 students and 80 staff.
- Not-for-profit NGO local organisation – health.
- Secondary school health centre.
- Specialist service of DHB hospital – we undertake outreach clinics with iwi providers and community centres in rural regions and community health centres.
- [We] support over 2,000 people with kidney failure in Northland, Auckland, Waikato, BOP, Tairāwhiti regions. We receive just \$25,000 government funding (DIAS contract).
- We also are members of Healthcare Aotearoa.
- We are a national business, which receives funding from either individuals, DHBs, or PHOs.
- We are a charitable trust affiliated to a national body, but independent.
- We are a DHB-funded child and adolescent mental health service operating within an Hauora.
- We are a DHB-owned and operated rural health centre including primary community hospital beds and ED.
- We are a District Nursing service attached to a DHB.
- We are a Hospice service – NGO.
- We are a Kaupapa Māori provider of integrated health, education and social services. We are also part of a Whānau Ora Collective.
- We are a local or regional non-profit organisation affiliated to a national organisation (not a branch).
- We are a national organisation – not a federated model.
- We are a non-profit organisation that is affiliated to a national body, but run separately.
- We are a rural health shuttle service in the [...] district that encompasses a large rural part of Northland. We take all peoples of all ages and all ethnicities to all health-related appointments.
- We are affiliated to a national non-profit organisation but are an autonomous organisation.
- We are also a peer-based NGO.
- We are an autonomous organisation, incorporated under our own right, but affiliated to a national non-profit organisation.
- We are part of a national NFP but are not a branch. There is a distinction and you have not made that option available. This is quite important.
- We provide budgeting, information and advocacy for the general public and we also have other health providers working from our location.

Respondents' roles included:

Acting Manager	Facilitator	Project Manager
Advocate (2)	Field Officer/Worker (7)	Project Worker
Area Co-ordinator	General Manager (2)	Psychiatrist
Area Manager (2)	GP	Public Health Nurse
Business Manager	Healthy Lifestyles & Social Determinants Advisor	Public Health Worker
CEO/Chief Executive (11)	Hearing Therapist (3)	Regional Manager
Clinical Hypnotherapist	Kai Whakapumau	Regional Representative
Clinical Leader	Kaimihi o Purapura Whetu	Registered Nurse (4)
Clinical Nurse Manager	Kaiwhakahaere	Registered Nurse/Care Manager
Clinical Nurse Specialist (2)	Manager (19)	RN/Team Leader
Clinical Psychologist	Manager/Educator	Rural Health Nurse Manager
Clinical Services Manager	Manager/RN	Rural Services Co-ordinator
Club Leader/Secretary	Managing Director	Secretary (2)
Community Cardiac Nurse	National Director	Secretary/Treasurer (2)
Community Health Worker/Manager	National Public Health Practice Leader	Senior Dietitian and Business Owner
Community Respiratory CNS	Nurse Educator (3)	Senior Occupational Therapist
Community Services Manager	Nurse Practitioner (2)	Senior Service Analyst
Community support worker/Community worker	Office Manager	Senior Services Co-ordinator (2)
Co-ordinator (11)	Operations Manager (2)	Service Delivery Manager
Deputy Chair	Owner	Service Manager (2)
Director (4)	Peer Support Worker	Services Co-ordinator
Director & Clinical Lecturer	Physiotherapist	Strengthening Families Co-ordinator (3)
Director & Registered Nurse	Practice Nurse (3)	Team Manager
Ecumenical Chaplain	Practice/Health Centre Manager (2)	Trainer/Development Manager
Educator	President (4)	Trustee
Executive Director (3)	Principal Health Advisor	
Executive Officer (2)	Programme Co-ordinator	

Respondents' organisations included:

Age Concern	Breast Cancer Aotearoa Coalition	Enable NZ
Age Concern Counties Manukau Inc.	Cafe for Youth Health (Taupo)	Endometriosis Waikato
Age Concern North Shore	Canterbury DHB	Epilepsy NZ (2)
Age Concern Rotorua	Canterbury Homebirth Association	Family & Community Services (MSD)
Age Concern Waitaki	Canterbury Osteoporosis Society	Family Start Dunedin
Age Concern Wanganui	Canterbury@Heart	FOCUS Independent Childbirth Education
Allergy ADHD Wanganui	Capital & Coast DHB (6)	Gateway Housing Trust
Allergy NZ Inc.	Care Co-ordination Centre (3)	Gisborne Parkinson's Society
Alzheimer's Canterbury	Caring for Carers	Gisborne Stroke Support Group Inc.
Alzheimer's Marlborough	CAS – Consumer & Advocacy Services of MHAPS Mental Health Advocacy & Peer Support	Gracelands
Alzheimer's Northland	Cashmere Counselling	Haemophilia Foundation of NZ
Alzheimer's NZ national office	CCS Disability Action (South-Mid Canterbury)	Head Injury Society of Southland Inc.
Alzheimer's Society Otago	Central Otago Health Services	Healthcamps NZ
Anglican Aged Care	Central PHO Horowhenua	Hearing Association (Hutt Valley Branch) Inc.
Anglican Care South Canterbury	Christchurch Resettlement Services	Heart Foundation (2)
Anthony Ray	Christchurch Women's Refuge	Hospice Mid-Northland
Communication Services	Counties Manukau DHB	Hospice South Canterbury Inc
Aotea Family Support Group	Crohn's & Colitis NZ	Howick Home Health Care
Arachnoiditis Sufferers Action & Monitoring Society (ASAMS) NZ Inc.	Deaf-Quip	Huakina Development Trust
Arai Te Uru Whare Hauora	Dept of Corrections	INP Medical Clinic
Arthritis NZ	DHDP – Drugs, Health & Development Project (Palmerston North)	Irlen Diagnostic Clinic Ltd
Aspire Canterbury	Diabetes NZ Horowhenua	Kahungunu Health Services – Choices
Asthma Canterbury	Diabetes Project Trust	Kaitaia Community House
Asthma Marlborough	Diabetes Youth Canterbury	Kakakura Health Services
Asthma South Canterbury	Disability Information Service	Kapiti Choices (2)
Asthma Waikato		Kidney Health NZ
Atareira		Kidney Society (Auckland)
Auckland Regional Public Health Service (ADHB)		Kites Trust (2)
Awhina Centre – NZ AIDS Foundation		La Leche League Area South Island
Bay of Plenty DHB		Lea Stening Health

Life Education Trust	Oasis Centre for Problem Gambling	Rangitāne o Tamaki nui a Rua
LIFE Unlimited Hearing Therapy Services Ltd (3)	Office of the Health & Disability Commissioner	Raukawa Charitable Trust
Like Minds Taranaki	Open Home Foundation	Raumano Health Trust
Linking Hands Inc.	Ora Toa	Red Cross NZ
Lung Health Auckland	Orthotic Centre (NZ) Ltd	Regional Consumer Network (Auckland)
Mangere Community Health Trust	Otago Mental Health Support Trust	Rehab People
Marlborough MS Society Inc	Overeaters Anonymous	Rotorua Hospice
ME/CFS Information & Support Services	Pacific Health Service Porirua	Royal NZ Plunket Society (4)
MidCentral Health	Palmerston North Women's Health Collective	Salvation Army, The (3)
Milton Community Health Trust	Parker Clinics, The (Hamilton)	SF Aoraki
Mind and Body Consultants	Parkinson's South Canterbury	Sleep Well Clinic
Ministry of Social Development	Pippal Wellness Clinic	Smokefree Coalition
Mothers Supporting Mothers	Podiatry NZ Inc.	South Waikato Pacific Islands Health Committee
Motor Neurone Disease Assn	Porirua-Kenepuru Hospitals	Southern DHB
Multiple Sclerosis & Parkinson's Society of Canterbury (Inc.)	Post-Natal Depression Support Network	Southern Suburbs (Wgtn) Stroke Club
Nar Anon	Post-Polio Support Group Otago	Spectrum Care Trust (2)
Nelson Multiple Sclerosis Society	Presbyterian Support Northern	Sport Waitakere
Nelson Women's Centre	Presbyterian Support Southland	Stewart Centre @ EIT
Newtown Union Health Service (2)	Problem Gambling Foundation	Strengthening Families (Family & Community Services, MSD)
Ngati Apa iwi	Prostate Cancer Foundation	Stroke Foundation Northern Region Inc.
Ngati Maniapoto Marae Pact Trust (NMMPT) Inc.	Public Health South	Stroke Foundation Southern Region Inc.
Ngati Porou Hauora	Pukekohe Cardiac Club	Suicide Prevention Information NZ
North Otago Asthma Society	Purapura Whetu Trust	Supporting Families Auckland
Northland DHB	Q-nique Ltd	Supporting Families in Mental Illness
Nurse Maude	QPMC – Queenspark Healthcare	Supporting Families Southland
NZ Continenence Association	R13 Trust	Supporting Families Wairarapa
NZ Police		
NZ Spinal Trust		

TADS (Training & Development Services)	Te Kupenga Hauora (Napier & Tauranga)	Waikato District Health Board
Behavioural Change Training	Te Puna Hauora	Wairarapa Asthma Society
Takapau Community Health Charitable Trust	Te Puna Waiora Māori Mental Health Services – Counties Manukau DHB	Wairarapa DHB
Taranaki Ostomy Society	Te Rapuora Health Services	Webhealth/Linkage Trust
Te Awamutu Zipper Cardiac Support Club	The Angel Fund	Wellink Trust
Te Awhi Whānau Charitable Trust	Think Hypnotherapy	West Auckland Mental Health Support Trust – Te Ata
Te Hauora Maioha	Tuhoe Matauranga Trust trading as Te Kaokao o Takapau	West Coast DHB (2)
Te Hauora Runanga O Wairarapa Inc.	Unichem Chemist Shop	Western Heights Health Centre
Te Korowai Aroha Pumau	Vakaola Pacific Community Health Inc.	Whānau Resource Centre
Te Korowai Hauora o Hauraki	Waahi Whaanui Trust	Women’s Health Council
	Waikato DHB	WONS: Well Women and Family Trust
		Wood Street Surgery

City/region where respondents based (when identified):

Auckland (20)	Henderson	North Canterbury (2)	Taranaki (3)
Bay Of Plenty	Hokitika	North Shore	Tauranga (2)
Blenheim	Howick	Oamaru	Te Awamutu (2)
Canterbury (3)	Huntly	Otago (3)	Te Tai Tokerau
Central Hawke's Bay	Invercargill (3)	Pakuranga	Temuka
Christchurch (20)	Kapiti (3)	Palmerston North (4)	Timaru (2)
Dannevirke	Levin	Papatoetoe	Waikato (4)
Dunedin (8)	Lower Hutt (2)	Porirua (5)	Waitara
Ellerslie	Mangere	Pukekohe (2)	Wairarapa
Gisborne (2)	Manukau	Rangiora	Waitakere (4)
Great Barrier Island	Masterton (4)	Reefton	Wanaka
Hamilton (5)	Maungaturoto	Remuera	Wanganui (2)
Hastings	Mercer north to the Cape	Rotorua (2)	Wellington (22)
Hauraki	Nationwide (2)	South Canterbury	Wellsford
Havelock North	Nelson (6)	Southland (5)	Whangarei (2)
Hawera	New Plymouth (2)	Taneatua	
Hawkes Bay (3)		Taradale	

District Health Boards (DHBs) respondents dealt with (when identified):

All (6)	Hutt Valley DHB (10)	Tairāwhiti DHB (6)
Auckland DHB (11)	Lakes (4)	Taranaki DHB (4)
Bay of Plenty DHB (5)	MidCentral DHB (8)	Waikato DHB (10)
Canterbury DHB (22)	Nelson Marlborough DHB (5)	Wairarapa (5)
Capital & Coast DHB (12)	Northland DHB (5)	Waitemata DHB (11)
Counties Manukau DHB (13)	South Canterbury DHB (6)	West Coast DHB (4)
Hawke's Bay DHB (5)	Southern DHB (15)	Whanganui DHB (3)

At least 36 respondents (approx 10 percent) indicated they dealt with more than one DHB.

Clients/consumers/patients

2. CLIENTS / CONSUMERS / PATIENTS / MEMBERS – We have a particular focus on working with or delivering services to (please tick all that apply):			
		Response Percent	Response Count
Maori		62.1%	215
Pacific people		48.6%	168
Asians		36.7%	127
Migrants/refugees		29.5%	102
Older people (65 plus)		58.4%	202
Youth (12-24 years)		49.4%	171
Children (0-11 years)		44.5%	154
People with chronic health issues		59.8%	207
Urban populations		54.0%	187
Rural communities		52.0%	180
Lower decile communities		56.1%	194
None of the above		7.2%	25
If you choose, please provide any additional comment about your clients/consumers/patients here: Show Responses			141
answered question			346

Comments about target groups included the following:

- Adult acute mental health inpatient.
- All consumers in New Zealand who have received a health or disability service from a health or disability service provider under *The Code of Health and Disability Services Consumers' Rights and The Health and Disability Commissioner (1994) ACT*.
- All of the above – we are a rural general practice.
- All people of working age, as well as all people with long-term health needs.
- All people with mental health & addiction problems.
- All people/ages who are housebound, who need visits from health professionals to restore their health to pre-injury/illness. All above boxes apply.
- All seeking employment in various industries.
- Any people over the age of 16.
- Any person with any degree of hearing loss who is over 16 years of age.
- Anyone who needs support.
- Anyone with epilepsy needs.
- Children 0-5 years and their families. (3)
- Clients are 16 years and over who may have a hearing impairment and their significant others.
- Contractual emphasis is on most at-risk parents and babies.
- DHB contract is to provide mental health services to refugees who have been traumatised and are survivors of torture.
- Disabled people.
- Everyone.
- Extensive Māori health provider with rural, urban and hospital health services.
- Families with children less than 5 years of all ethnicities living anywhere in NZ.
- General Practice/Urban – so have a cradle-to-grave population base.
- Health workers.
- Hospice patients.
- I have ticked all boxes because we are a service provider that delivers a range of services to disabled people – a group I note you seem to have excluded from your demographic! Disabled people are present throughout our communities through every ethnic, geographic, urban, rural and age-related demographic.
- I work for a DHB – we serve across all age ranges and across ethnic identities.
- I work for a membership professional body.
- I work within a Māori mental health residential facility catering for 8 Takata Whaiora ranging in age from 21 to 59. They have a range of mental health prognosis and are placed here to transition back into the community.
- Large proportion of our clientele is on benefits ranging from DPB, Unemployment, Sickness or National Superannuation.

- Less than 2% of our patients are non-Europeans although 2yrs ago we did receive PHO funding to work with those with BMIs over 35, which included a greater range of people from different ethnic groups and lower decile communities.
- Men who have sex with men and gay or bisexually identified men.
- Mental health/pregnant/new mothers. All socio-economic groups. All ethnicity, although primarily Māori/European.
- New Zealand women of all ethnicities and nationalities and their families – both rural and urban.
- Non-enrolled population – fee for service to clients. All population and age groups.
- Our clients are 18 years and older with mental health needs in the primary care environment, that are referred from GPs.
- Our clients are families and whānau of people who have mental illness, so it encompasses all of the local community.
- Our clients are older adults with high support needs due to their health status.
- Our 'clients' are our practitioner members. They would treat all of the groups mentioned above between them.
- Our clients are people with chronic kidney disease/kidney failure including pre-dialysis, dialysis and transplant, as well as those choosing supportive care, rather than dialysis.
- Our clients have all had a stroke and nearly all will have a physical or cognitive disability. We are very concerned about the increase in young Māori and Pacific people having strokes.
- Our focus is bipolar disorder.
- Our focus is on all needs of the people in our communities.
- Our membership and delivery of education and support services is provided to stroke survivors, their family members and carers, as well as the general public of all race, age, religious and gender groups in the Wellington area.
- Our mental health patients often have the greatest need and biggest challenges.
- Our organisation offers a free service to adults aged 16 years +. We offer aural rehabilitation services to people with hearing impairment and their families.
- Our organisation works with anyone regardless of ethnicity who has had polio – the majority are over 60 years of age.
- Our outreach service targets older sicker poorer.
- Our primary client base is women and children.
- Our service is open to all older people from 60ish and occasionally those under 60 who may need our help. Māori, Pacific, Asian.....all are able to access our services.
- Our service users are referred for a variety of reasons and usually come with a number of health conditions, probably dementia and or personality and or mental health disorders. They may need support (advocacy, facilitation and mentoring) for social connection, health and well-being (i.e. accessing their health providers) house and paperwork management or support for financial, budgetary or WINZ entitlements, transition to residential care – all levels. The aim is that the service user feels able to make positive changes in their lives, with a view to becoming more independent.

- Our services are aimed at the family as a whole but we generally work with older people and their adult children. Our services are available to any and all ethnic groups but, being in the lower South Island, there is not the diversity that is found in the North Island.
- Our services are primarily for, but not exclusive to, Pacific peoples.
- People suffering from mental illness over the age 18 years.
- People who have mental health issues.
- People with arthritis. Profile of clients has changed over past five years – % of Māori clients increased; % of Pacific clients increased (now 20% of northern region clients). Half of all clients of working age.
- People with disabilities.
- Population based approach. The role I have within the organisation involves working within another government agency to assist clients to better access primary health services.
- Population health for the entire district is in our annual plan and focus.
- Pregnant woman of all ages – we provide ante-natal education for.
- Services are available to total DHB population.
- Several of our contracts are mental health focused, plus one received funding from ACC.
- Small GP practice, urban, lower decile, about 65% Māori.
- Small rural services covering everything.
- Support to families with children under 17 years old where there is either care and protection concerns for the children, or one or more of the children have a disability – particularly autism and ID.
- Take patients from all over central NZ (Wellington, top of the South, up to Gisborne and across to Taranaki).
- The group we work with is people with disabilities.
- The objectives of the branch are to promote and advance the interests and well-being of all persons with hearing impairment living in the Lower Hutt, Wainuiomata, Eastbourne, Petone and Upper Hutt areas. Whilst we will help all people with hearing loss, we appear to attract the older age group on a limited income.
- The training programme we deliver is generic in its delivery and involves all population groups and the wider occupational workforce trained in its implementation.
- There is a discrepancy between the ideal and reality due to lack of resources.
- There is nothing in place for the chronically ill people rurally for hospital appointments; we do have a bus that leaves 7am and does not return till 6pm – not good enough for patients. And all day patients do not get a meal. WHY???
- This trust works with mental health clients.
- Urban inner city medical practice.
- We also deal with adults in the 30 to 50 year old bracket.
- We also particularly target other marginalised communities, unemployed, low income, prison releasees, mental health patients, people with drug and alcohol problems.

- We are a DHB and as such, link services to the clinical needs analysis for our area, which has a particular focus as above.
- We are a membership-based networking and information organisation. Our membership is across a range of consumers, consumer groups, DHB & NGO service providers, government agencies and community organisations. Our contract covers the adult (18-65) age group.
- We are a mental health organisation. We can cover all age and ethnicity groups. Our contracts with the Ministry of Health are in relation to reducing discrimination associated with mental illness and have wide target audiences from individuals, organisations to general public.
- We are a not-for-profit organisation with a Well Child contract with the MoH to see 85% of all new baby cases.
- We are a pan-disability service – our purpose is to work alongside individuals to develop their skills and abilities and enhance their inclusion in the communities of their choice. Our rehab services work with people returning to community, personal and work following illness or injury.
- We are an organisation that works with people with physical disabilities.
- We are dedicated to providing practical and financial support to patients and their families affected by tuberculosis and other respiratory illnesses.
- We are here to support anyone with heart problems, especially cardiac surgery.
- We cater for all ethnic groups and all ages.
- We cater to all ages, cultures and economic groups through the services we provide, being social, health and environmental.
- We consider referrals from ages 18 years upwards.
- We cover all ages, geographical locations and ethnic groups, however the majority of our service relates to the over 65 age group with chronic health problems.
- We deliver social services to all people in Canterbury and Westland, including aged care, city mission, family and community.
- We do not have a particular focus and apart from very young children, under the age of 4, work with all areas. The one area we do not work in is with people who have serious psychiatric disorders such as schizophrenia.
- We engage with youth offenders for accountability to victims, prevention initiatives, community ed programme Waka-ama, army life skills.
- We focus on all patients with a life-limiting illness regardless of age or ethnicity.
- We focus on people who use mental health services in any age or ethnic group.
- We have a broad generalist focus, but recently completed a project that targeted low decile, high health needs population.
- We have a particular focus on working with and delivering services to people of all ethnic groups from the age of 6 years to 65 plus who suffer from Meares/Irlen Syndrome, which is a visual perceptual problem. Common problems associated with Irlen Syndrome are: Light sensitivity – especially when working under fluorescent lights. Inefficient reading/Difficulty reading print – because it shifts, shakes, blurs, moves, doubles, disappears or becomes difficult to perceive. Slow reading rate – Inability to read letters,

numbers or words in groups. Problems tracking, correctly identifying words, skimming or speed reading. Strain or fatigue – Strain, tension, fatigue or headaches when reading or studying. Attention deficit – Problems concentrating while reading or doing written work. Difficulty staying on task – Look away from the page, become restless, fidgety or tired. Poor depth perception – Inability to accurately judge distance or spatial relationships. May accidentally bump into others. May be unsure or have difficulty with stairs and ball sports. Irlen Syndrome is not an optical problem. It is a problem with the brain's ability to process visual information.

- We have four services:
 1. We work with family/whānau of people who have mental health issues.
 2. We provide temporary housing for people who have mental health and addiction issues.
 3. We provide training and employment preparation for people with mental health and addiction issues.
 4. We undertake health promotion in secondary schools on mental health and the associated stigma. Our services all have a different particular focus.
- We have involvement with all lower socio-economic communities – including those with disabilities and chronic health conditions.
- We offer services to all children aged 5-12 and their families who have a range of health, social, behavioural issues.
- We offer support to those with Parkinson's, their carers, families and supporters irrespective of ethnicity or age.
- We particularly focus on people who fall through the cracks, refugees and new migrants, long-term mental health consumers, people with addictions. We have a midwifery service integrated into our primary care service. We run outreach services in low decile suburbs.
- We predominantly provide care for urban residents, but at times we work with rural people.
- We primarily work with adults in our service delivery.
- We provide a confidential, non-judgmental and anonymous health service to all people, all ethnicity and across all ages.
- We provide a free service to community and people affected by a condition that can happen in any age group, gender or ethnicity.
- We provide advocacy and peer support to adults ranging from 18 years of age onwards. (2)
- We provide fundraising and support to our local hospital, which has a general surgical ward as well as an 8 bed maternity ward. We support all age groups.
- We provide health services to all.
- We provide health services to people of all genders, ages and ethnicities.
- We provide hospice palliative care for all people regardless of age, ethnicity, culture or financial situations.

- We provide public health services for populations (not individuals) and support infrastructure for public health. As the office of a nationwide organisation we provide support and co-ordination for our members.
- We provide services for children, young people and adults with disabilities and their families. Our services include 24-hour support for people living in residential homes throughout the Auckland and Waikato regions, specialised home support, behavioural and aspiration services for people in the greater Auckland region, and respite care for children aged 0 to 17 in the Auckland region and adults in the Waikato and Bay of Plenty areas.
- We provide services to all ages, all ethnic groups.
- We provide services to disabled people.
- We provide social work support, information, education and promotion to the dementia community in Canterbury and more recently on the West Coast. Whilst most of our clients are aged over 65 years, we are also the only specialist community-based service providing the above services to those with dementia aged under 65 years. All types of dementia are covered within our service, not just Alzheimer's type (i.e. vascular, alcohol etc.) Our aim is to make life better for all people affected by dementia.
- [We] provide support and information to any person who has epilepsy. We also offer this information and support to the person's family/whānau. We provide information and staff training to schools, rest homes, residential care providers, employers, govt depts anyone who needs to know about epilepsy. One in fifty people will develop epilepsy at some stage in their life.
- We provide support to family, whānau, caregivers for those supporting/caring for a family member or a person with a mental illness – we work across all age groups – have a group for children whose parents have a mental illness.
- We provide support to the 50+ age group through education and information. Our organisation is actively involved in providing elder abuse and neglect prevention within residential facilities. This training was developed by our organisation to meet the local needs of caregivers within our residential care facilities.
- We specifically promote education and awareness of continence.
- We support bereaved parents who have lost a baby, whether through pregnancy, birth or a newborn – we therefore support any parent from any race, religion or area.
- We support, advocate, educate and supply information to all people of all ethnic groups and ages.
- We work with all women and their children. Presenting issues are frequently: family violence, rape and sexual abuse, mental health or physical health issues, need for emergency or rental housing, financial hardship and domestic crisis.
- We work with anyone who has a spinal impairment.
- We work with children and adults who have learning disabilities, including Irlen Syndrome – a perceptual reading disability including light sensitivity that may assist with migraines. Sufferers may experience eye strain, headaches, inattention, ADD-type symptoms, words may be fuzzy, move etc. A full optometric assessment is required before an Irlen tinting is done. Additionally, reading problems including dyslexia. (We use

Services provided

3. SERVICES – Primary health care is first level contact with essential, practical health care that is universally accessible to people in the community. With this in mind, please indicate which primary health care services your organisation provides – if any. (Please tick all that apply):

[Create Chart](#) [Download](#)

		Response Percent	Response Count
GP services		19.3%	68
Nursing services		37.7%	133
Screening services		28.9%	102
Sexual health services		20.7%	73
Mental health services		33.4%	118
Counselling services		28.0%	99
Parenting support services		21.2%	75
Health education or promotion		56.9%	201
Advice on nutrition and/or physical activity		41.4%	146
Aged care		21.0%	74
Smoking cessation services		31.4%	111
Alcohol and drug dependency support		19.3%	68
In-home support services		22.1%	78
Transport and accessibility supports		21.8%	77
Other health services (note details in box below)		22.9%	81
We do not provide Primary Health Care services		18.1%	64
If you choose, you can make comment about your services here: Show Responses			143
answered question			353

Extra detail provided about services included the following:

- A disability information service.
- ACC providers.
- After hours care provider.
- After hours service.
- All employment-related health issues.
- All our clients are under GP services.

- Allied health services.
- Although we are not a primary health care provider, we support our client base in all health-related areas of their daily living activities and when they age or develop chronic health conditions. Many of the people we support have a form of mental illness or have multiple disabilities where specialised supports are mandatory.
- As a pharmacy, we have many patients who self refer to our services, largely seeking advice and often acute treatment. Additionally, our medication services are part of those supplied in conjunction with prescribers. The accessibility offered by community pharmacy is greatly valued by patients and a good example of how pharmacy is already living the *Better, Sooner, More Convenient* ethos.
- Birthing and post-natal services.
- Community support.
- Dental health education. School-based nursing. Suicide prevention.
- Diabetes specialist service. (2)
- DIAS (Disability Information and Advisory Service).
- Disability support services and advocacy.
- Easy breathing classes every [week], and provide all nebulisers for those who have been referred either by their own doctor or hospital.
- Elder abuse and neglect prevention. Accredited visiting service (reduce social isolation). Handyman fieldworker service. Total mobility assessment. Information advice and support. Community offices. Community development.
- Elder abuse and neglect prevention. Volunteer visiting services. Information and advocacy services. Total mobility assessor.
- Elder abuse education.
- Emergency services including PRIME.
- Free women's health information, referral assistance, support, advocacy and some personal health services – pregnancy testing, cervical screening priority clinic. Subsidised counselling service (can be free) and access to lower cost natural health practitioners, such as osteopath and massage.
- Funding primary health services.
- Hospice care.
- I have ticked 'In home support services' however we do not have the mandate for access issues, e.g. getting a person's WINZ benefit or lawn mowing etc.
- I work in nursing administration, specialist services for older people. Now incorporates mental health services for older people.
- I would define our work around empowering the older person to visit or access social and health support services. We do transport to health appointments, will visit in hospital etc if the service user requires supervision, and/or advocacy if they do not have the financial means to do so privately. We educate a lot of service users, their whānau and supports around safety, nutrition, and how they can progress to where they would like to go. The nursing services are around advocacy and facilitation, e.g. referral to ACC or their GP or

audiologist and then we see them through these processes until they have their hearing aid, getting their script, in-home supports increased, or cataract op done.

- Immunisation programmes. (2)
- Includes specialist services.
- Information service.
- In-service training to rest home staff and to health professionals.
- Irlen assessment is a two-step process.
 1. A Screening session determines whether a person has Irlen Syndrome, how severe it is and whether an Irlen coloured overlay can help.
 2. A Diagnostic session determines the precise colours which filter out the wavelengths of light, which are causing the client's perceptual difficulties.
- N.B. Before Irlen filters are supplied, the client must be examined by an optometrist or ophthalmologist as perceptual symptoms can be caused by medical or optical problems, as well as Irlen Syndrome.
- Maternity, palliative care.
- Mental health focus, health and social needs focus.
- Mental health service for people with mild to moderate mental health needs.
- Midwifery care. (2)
- Midwifery services, antenatal/postnatal education. Department of Corrections contract and Early Education contract.
- Mobile cervical screening services. Health professional training for primary health care sector.
- Mobile nursing services.
- Naturopathic treatment, complementary medicine (nutrition diet, herbal medicine homoeopathy) for a range of health complaints, with a special focus on mental health if applicable, for those who, for whatever reason, chose not to have mainstream health care.
- NGO – Community-supported accommodation service catering for people with an ongoing (L3 RSS) mental health disability.
- NP specific services.
- Nurse practitioner clinics.
- Occupational health.
- Officially we do not provide primary services as we are a DHB, however many of the services identified above are what our staff provide when working in the community.
- Osteopathy and radiology are on site, as is a pharmacy and laboratory facility.
- Other organisations use our facilities on a timetabled basis – Plunket, midwives, hearing tests, cervical screens, Work & Income.
- [Our] community co-ordinator acts on referrals of stroke survivors and provides invaluable assistance at this traumatic time in their lives. The carers particularly are grateful for the help given.
- Our core service is support and education in relation to domestic violence.

- Our service includes practical/emotional support specialising in the effects of renal failure rather than counselling. Also support/advice re treatment choices and especially end of life issues. Working largely with tertiary renal services, our work in the community is primary health care.
- Our service provides rehabilitation services to people who have brain injuries as a result of either a trauma or a medical condition, e.g. stroke.
- Our volunteer arm raises funds to provide a large number of support services to families/whānau with children 0-5 years. Services include parenting courses, car seat rental schemes, support groups for parents of children with autism, water confidence classes, post-natal depression support, book club, music and movement classes etc.
- Our volunteers provide free breastfeeding information and support, with some parenting information.
- Pastoral care, support and counselling for in-patients/clients in General and Psychiatric Service facilities; and on request from former patients now in community settings. Also for relatives and friends of in-patients/clients. Also for a wide range of staff, from professionals, nurses, therapists, to domestics and artisans in both general and psych. service settings. We also provide spiritual/sacramental care, both individually and in group and gathered situations, e.g. the chapel. These involve patients, relatives and friends and staff.
- Peer support to people using acute inpatient mental health services.
- Physiotherapy assessment and input/referral.
- Physiotherapy.
- Podiatry care and information.
- Prescribing Nurse Practitioner services.
- Problem gambling.
- Provide cardiac education/rehabilitation in the home.
- Provide disability information, advice and support to Pacific population.
- Provider arm of Māori Mental Health Service of DHB.
- Provision of devices and equipment to support those with chronic disease (i.e. nebulisers for COPD).
- Psychology service.
- Regarding the GP and nursing services, we work in co-operation with another organisation, for which we run 3 free health clinics in the Franklin district, which cater to the lower socio-economic communities.
- Residential and home alcohol and drug dependency services and home detoxification services.
- Rongoa and Mirimiri.
- Savings and loans referrals from social services at hospitals.
- School health. Diabetes. Child health. Palliative care. Specialist wound care.
- School nursing.
- Service navigation in regards to health and social services.

- Smoking cessation in this context is referral to smoking cessation services. Screening refers to non-invasive procedures, e.g. weight, BP etc.
- Social work services, podiatry, massage.
- Social work support.
- Specialist palliative community care.
- Support for families of children with chronic health condition.
- Support for people with hearing loss, and tinnitus.
- Telephone parenting and health advice and support.
- The health care we provide is mainly information. Information on mental illness and addictions, treatment options and services. We also provide support and advocacy and practical services such as housing and training, but most of the support we provide is social and community support such as accessing food, shelter and other health and community services.
- The organisation provides funding for primary health care services and funding to access unmet health needs.
- The training programme is based on early identification and early prevention covering all lifestyle behaviours and mental health risks. 'Alcohol and drug dependency support' as indicated above is not accurate for our service, as it is not about addictions but prevention, but there is no box which accurately defines our service.
- Treatment of injuries/illness in the home esp. allied health services (physiotherapy, occupational therapy, social work, nursing, speech and language therapy).
- [We] advocate for all members regardless of race. We are a vital link to all primary health care services, e.g. health professionals, GP, SupportNet, Enable, Wheelcare solutions and hospice.
- We also provide vocational consultations to people who have serious injuries.
- We are a community mental health service.
- We are a community-based trust that provides direct to its customer base. All trustees work in community, who also deliver essential service, i.e. training programmes, parenting support, solution-focused counselling, Child Youth & Family, Police.
- We are a hospice, so therefore we provide care and support for clients who have an end-of-life illness. We provide a variety of services and support their families/whānau through this time.
- We are a needs assessment agency and a one point of entry for all community-based services.
- We are a patient-driven organisation, which provides information, education and support to people living with allergies. However with the help of our medical panel, we also provide information and education resources to health professionals at primary health care level, to assist them in better providing essential practical health care. None of this work is funded by DHBs or government.
- We are a social housing service contracted to provide community support services.

- We are a support and rehabilitation group mainly for people who have suffered a heart attack etc. However we also have members who are undergoing therapy for cancer and other medical problems.
- We are a support group for families of children with chronic health conditions and provide financial, practical and emotional support, as well as information.
- We are a tertiary service.
- We are an emergency department and provide many aspects of the services above, but mainly just incidental primary health care within and out of normal business hours. We would be better able to do the work we are expected to do, if we did not have to manage care for patients who CANNOT ACCESS primary care for reasons of cost and availability.
- [We are] an innovative youth 'one stop shop' health and support service – providing free health and support services for young people aged 11 – 25 years. [We] currently have 4,500 young people registered with the service. [We] have a long standing relationship, with a good reputation for providing quality services within our community, and most importantly among our young people. This is reflected by the number of self and family referrals, as well as referrals received by statutory and community agencies. Young people see [us] as a safe and confidential place to come and know that when they engage with the service they will be treated with respect and care. While we work within clear boundaries and guidelines, we recognise the importance of responding to that young person's immediate and long-term needs. [We] provide an integrated service with professional staff who are committed to providing a high standard of practice and have the skills to utilise the multidisciplinary team to assess each individual and respond effectively. Staff include peer support workers, doctors, nurses, social worker, counsellors, and mentor. Services and programmes [here] are delivered in a manner that is non-judgmental, culturally appropriate and respectful to young people – this then promotes a climate of trust, confidentiality and safety. The services and programmes are holistic, strengths-based, focus on improving their overall health and well-being and encourage long-term independence.
- [We] are involved with providing antenatal classes specific to homebirth. We are in the process of picking up the management of these classes, which do receive some/minimal funding from MoH, as the major players are having to move aside.
- We are not a health provider, but a support service and information provider.
- We are primarily a service and referral agency that provides elder abuse and neglect prevention, an accredited visiting service, health promotion and public awareness, transport service, and community service to those who need support, information and advocacy.
- We could be doing a lot more health promotion and education. It is much needed in the local community.
- We do however provide information, advocacy and support on all of the above services.
- We do not deliver or provide care. Our function is one of assessment and co-ordination of services.
- We do not provide primary health service but our OTs would like to work more closely with GPs and employers to assist people in their early recovery at work.

- We do not provide primary services, but follow-up services after hospital and acute rehabilitation primary health services in the following areas noted above: counselling services, health education and promotion, advice on nutrition and physical activity, in home support, mentoring and transport and accessibility support. We also provide, telephone contact, free driver support where needed, twice monthly meetings, weekly hydrotherapy classes, monthly physiotherapy exercises, a carers support group and a young strokes support group – the latter two meeting 6 weekly.
- We do not supply primary health care services but we refer our clients to the relevant services.
- We enjoy a partnership with a Māori health provider and work to provide cooking classes, mirimiri (massage), walking groups, and gardening. We have a separate contract to provide intensive cessation support. We also work with Plunket to provide a parents coffee group and parenting classes and we are also able to work with diabetes educators, arthritis educators and community mental health nurse to provide specialist clinics.
- We give advice on harm reduction regarding drug use. We provide front line care to people who choose to inject via education, advocacy and the needle exchange programme. We also refer people who are wanting help with addiction or injecting into other help services, A and OD and/or mental health services across a wide range.
- We give education, support and community awareness, for everybody who has asthma or any respiratory conditions.
- We have three GPs and one NP along with 2 RNs and clinic manager and front office support staff.
- We have field officers throughout NZ delivering educational and health services to persons with epilepsy and their families and the wider community. Aim to raise awareness and inform people better so they can actively live a life with the best control of the condition possible. We make referrals to other agencies, link people to support groups and generally visit people with epilepsy in their homes and increase knowledge and skills.
- [We] offer investigation and treatments for those suffering from sleep disorders. This includes ALL sleep disorders, including insomnia, snoring/sleep apnoea, children/baby's sleep difficulties, shift work management, parasomnias (sleepwalking/night terrors, REM sleep behaviour disorder, restless leg syndrome, narcolepsy, etc). Clients are referred from primary health and specialists, and may self refer. I have no funding for these clinics despite offering an affordable private service. In addition I am committed to education of both the medical profession, and the general public. This involves lectures/seminars, and meetings for all sections of society from business enterprises, medical conferences to community groups. Some of these are paid, many others are community service only.
- We often refer people to counselling.
- We provide all of the above.
- We provide aural rehabilitation services as per Q2, which includes informational counselling and support with adjustment to hearing loss.
- We provide bi-monthly, free cervical smear clinics (through a very small arrangement with Public Health). We offer free counselling for women (up to 10 sessions for general issues), 20-30 sessions for rape/sexual abuse. We also have 2 social workers who do

some advocacy for clients in sessions with doctors, dentists, the hospital, when the client has no other support and is too unwell to communicate effectively on their own.

- We provide both FREE counselling services and a Public Health service in our region.
- We provide budgeting services and information and advocacy.
- We provide community services of an advocacy nature.
- We provide day respite care for people with dementia, support, education and advocacy for family carers; education for professional carers and awareness in the community.
- We provide education, information and support about breast cancer. We refer people on to appropriate services and we communicate with them individually by e mail, phone and meeting with them to do these tasks. Our information is evidence-based and we work with health professionals to ensure this.
- We provide education, information and support in order that people can make an informed choice on services, organisations, lifestyle choices etc.
- We provide essential community support services and access to same.
- We provide health promotion services.
- We provide information on a wide range of service agencies that exist within our community, which allows people to access those agencies.
- We provide information, advocacy, referral and support on a wide range of women's health issues.
- We provide information, education, advocacy and support to those family, whānau and caregivers caring for a person with a mental illness.
- We provide mental health assessments for GPs; primary mental health funding to transition clients to GPs.
- We provide one-to-one support in the home to families in the form of information, education, counselling, liaison, assessment. We also provide avenues for peer support in group format and education in a variety of ways; seminars, courses, written and other resources. We're often the conduit for access to other services and act as liaison and/or referrer for these.
- We provide pet therapy.
- We provide screening hearing tests, hearing age management, minor hearing aid repairs, Tinnitus counselling, etc.
- We provide support to bereaved parents – we are not health care professionals, but bereaved parents ourselves.
- [We] provide support to family members and friends who care for someone with a long-term disability or chronic ill health.
- We provide support, advocacy and education to families and the community on mental health and drug and alcohol related issues.
- We provide support, advocacy and education to families and whānau about mental illness and family well-being.
- We provide the planning and funding services for primary health care services across the entire spectrum of delivery for the district.
- We provide translation and interpretation to Pacific peoples either at GP or specialists.

- We provide urgent, acute and long-term orthotic services to patients referred from primary, secondary and tertiary referrers with patients requiring orthotic therapy.
- We refer those with ME/CFS to specialist services etc where necessary.
- We specialise in providing home and community-based support and education for people with dementia and their carers and family.
- We work with counselling and clinical hypnotherapy. We work with individuals for one-on-one sessions and we also provide group sessions for some of the components of our programmes. Any counselling is done in one-on-one sessions.
- We work with the primary and secondary providers.
- Whānau Ora, Oranga Wairua carving programme, *Like Minds Like Mine* anti-discrimination programme, Mirimiri/Massage, Kaumatua support group.
- While many of these services are available within the DHB area (GP, screening), mental health is mainly 2ndry & 3tiary; parenting support; aged care but I am unsure if they are all provided by the DHB, so I have not ticked them.
- While we provide these services, in very few places are they supported through primary care funding. We do have a small contract with [the] PHO to deliver under the chronic care framework.
- Work and Income indirectly funds access to primary health services through the disability allowance.
- Would like to provide a range of services outlined above, sadly no-one provides these specific services aimed at Deaf/hearing impaired population in their native language NZSL.
- Your definition of primary health care is a slightly curious mix – a little flavour of [Alma Ata](#), but not quite. We provide health promotion, but not in a way that fits your primary care definition.



Relationships with GPs and medical centres

4. RELATIONSHIPS WITH GPs & MEDICAL CENTRES – Thinking about your interactions with GPs and medical centres over the past two years, please tick all that apply to your organisation and your experience of primary health care services: [Create Chart](#) [Download](#)

	Response Percent	Response Count
We are based in a medical centre or Integrated Family Health Centre	14.0%	46
We regularly make referrals to GPs/medical centres	39.6%	130
We regularly receive referrals from GPs/medical centres	55.2%	181
There is an Integrated Family Health Centre established in a region we work in	11.3%	37
We initiated contact with GPs/medical centres to discuss ways to work together to assist the clients/consumers/patients we have in common	53.4%	175
A GP/medical centre initiated contact with us to discuss ways to work together to assist the clients/consumers/patients we have in common	25.0%	82
We have no interaction with GPs/medical centres	8.2%	27
We do not see any value in building relationships with GPs/medical centres	0.3%	1
We have worked collaboratively on at least one project/initiative/pathway with a GP/medical centre	34.5%	113
Please specify your most effective collaborative activities or provide brief details about your recent relationships with GPs/medical centres Show Responses		151
answered question		328

Comments about relationships and examples of collaboration with GPs and medical centres included the following:

- 100% Breast Screening achieved.
- 3x Whare Oranga in Pukekohe, Port Waikato and Mangatangi in collaboration with ProCare. GPs and nurses give their time to these clinics to provide free medical services.
- Access to free cervical screening is becoming much more difficult due to funding changes, and GPs (or their nurses) contact us periodically to find out what we can provide. Such screening is most needed by women on low-incomes (e.g. have Community Services Card). We get many referrals from GPs to our free counselling and social work support services. When women are new to Nelson or dissatisfied with their existing GP, they come to us for recommendations on other GPs.

- As [a] Senior Services programme, we have volunteers who assist the elderly to attend appointments etc.
- Chronic care management programmes. Smoking cessation in pregnancy. Retinal screening programmes. Mental health nurse services. Dietitian services. Podiatry services. StrepA swab programme for detection of Rheumatic fever.
- Collaboration with GP practices via Practice Nurse interaction is the most effective way to alert, influence care or get information about treatment. We also accompany patients to appointments to provide advocacy.
- Communication occurs mostly with practice nurses and/or reception staff at GP Practice and/or community hospital staff and/or midwives. e.g. Client/whānau advocacy, continuity of care, new referrals etc.
- Contracts with GPs who regularly visit residents in our aged residential care facilities. Recent participation by one of our contracted GPs in a Restraints Monitoring Group.
- Currently establishing family health centre. Our weekly community cardiology clinic in our rural community works well with GPs referring patients to the cardiology with availability of ETT, echos and holter monitors alongside specialist cardiac nurses.
- Currently work with Gonville Health Wanganui.
- Establishing Pelvic Floor clinic with physio in GP practice.
- For the use of our nebulisers. Set up a system between all GPs/medical centres and hospital for nebuliser use. Work with the respiratory nurses who regularly attend the Masterton breathing group but not the Greytown one. We cover the entire Wairarapa area. Towns, country and coasts.
- Gonville Health Wanganui.
- GP referrals are usually about their patients' need for advocacy in dealing with other health or disability providers.
- GPs are important to us, but many either deny the existence of Post Polio Syndrome or know little or nothing about it. Some are most supportive and we treasure them. We offer booklets to any health professionals who are willing to read them. The University of Otago Medical School does not teach students about Post Polio, but sends 2nd or 3rd year students out to visit the elderly in their homes, then they report back to their class. We see this as a good programme as some of our group are on that list and so our voice is heard in a small way.
- Health promotion projects – Men's health week free checks.
- I am on the Midlands Health Network Community Advisory Panel and our organisation works closely with the Taranaki sector of the Midlands Health Network on a number of projects.
- I and some of our staff have visited most of the GP practices in the area. Also we are within, though not a functional part of, an hauora and I frequently consult in person with the practice nurses and doctors.
- I have made referrals to GPs to ask them to refer an older person for re-assessment by their DHB Nasc for increase in homecare. I have also notified GPs of changes in an older person's health or suicidal ideation.

- I have recently held a meeting with a group of GPs to inform them of the services that our agency provides and seek to work more closely with them.
- I work in a medical centre with GPs, nurses.
- Implementation of a formal Advance Care Planning process within the organisation – contacted all GP practices seeking feedback. Some received. Also correspondence with GPs on a case-by-case basis about Advance Care Planning for their patients. Most GPs appear to welcome the process, but acknowledge lack of time for them to lead it. There has been no negative feedback.
- In Canterbury, we work closely with GPs to ensure services and supports are in place to prevent hospital admissions. This has been a particular focus since the earthquake. In Canterbury and Wellington, referrals for GPs to provide a simple seamless process for them to free-up time for more crucial work. In Canterbury, Wellington and the Hutt Valley, we have worked in partnership with GPs to assess clients and ensure correct levels of home-based support for the over-65 age group in line with DHB guidelines.
- In our region there are three Union health services, which have the majority of our clients as patients. We have worked with all three and they now have dedicated staff to serve refugee patients. We meet with each of the three Union health refugee teams on a monthly basis. This relationship works well professionally and is of significant benefit to their patients, our clients.
- Individual client management – resulting in the client’s needs being met in the manner that the client wished. Involved collaboration between hospice, district nurses, whānau ora and the GP.
- Meeting with GPs to manage safe return to work of patients – this needs to grow however.
- Mental health clinic established in a local marae GP practice/clinic. Currently establishing a similar, though more expansive, service in a rural integrated family health centre.
- Most of our referrals come from hospitals, but we have been involved in the GAIHN project in Auckland when I chaired the Long-term Conditions Clinical Team.
- Most of our referrals come from Tairāwhiti District Health.
- My experience with GPs/medical centres would be the referral of a person that may need to make application for discounted taxi fares, as you are not allowed to drive until you have been seizure free for 12 months. Other referrals may be due to the waitlist people are facing to receive a time with a neurologist (12mths), so the GP will refer to us while they wait for a neurologist. I would refer to a GP if the person I am working with has no GP or I feel they need to see their GP as things are not going well for them.
- None of the above really fits us, as we do not have clients or patients as such, so don't have a lot to do with GPs, however we supply resources and answer questions occasionally. We also promote and run professional development suited to nurses. I did not want to answer 'do not see any value...' because I do believe there is value in the small relationship we have, and certainly potential for additional value.
- Note re above: Although we regularly refer our community/people to GPs/medical centres, injecting drug users have a stigma attached where they are not treated well in mainstream care. I believe this to be a direct result of:
 - 1 – A shortage of GPs available in the Manawatu area.

2 – Injecting drug use/addiction/beneficiary ‘friendly’ GPs and medical staff is lacking in the area due to the shortage of GPs.

3 – Waiting lists for GPs is common for all people in the area.

- Occasionally we receive referrals from GPs, and their surgeries are visited each year to inform them about our support service.
- Only relationship this organisation has with GPs is in relation to mental health clients who we support. Almost always initiated by the client. Generally very difficult for our staff to meet with GPs (even if in relation to a mutual client for whom the GP is case managing their MH needs). Agency is often expected to pay for an appointment. Responsiveness generally from GPs (e.g. phone messages) often poor.
- Our 2010 national conference was approved by RNZCGPs for CME points. Our ACC-funded brochure on anaphylaxis was launched in association with a seminar for medical staff from a number of centres, presented by the Clinical Director from Auckland City Hospital.
- [Our] clinic works in integrated health centre.
- Our current interest is to identify and support the development of health promotion in primary care.
- Our interaction with GPs and PHOs is limited. We have been in touch with some of them to leave our support packs with them. We would like to work more collaboratively with them.
- Our organisation provided consultation services to the RACP, the RNZCGP, the Paediatric Society, the NZMA, during submission process to the Health Select Committee on the Smokefree Environments Amendment (controls and enforcements) Bill. We encouraged these organisations to disseminate our consultancy outwards to their workforce populations for individual submission writing.
- Our PHO is situated in another district and our medical centre is one of several. It is not well-serviced with doctors, and clients are often asked to get themselves to another clinic due to lack of appointment times available, and with this, we help transport the client to the appointment. It is not very satisfactory, but there does not seem to be anything they can do about it.
- Our service is a GP-developed service.
- Paracetamol poisoning prevention project.
- Part of my role is to do education sessions to medical centres and usually the centre will contact the advocate. Complaints resolution is a huge part of our work, which involves a consumer letter or setting up a meeting with the provider, which the advocate usually facilitates.
- Patients are referred to us for x-ray and review, for dressings and follow-up care at weekends and after hours. Patients can also be referred for the wrong reasons and for services we do not provide.
- Personally speaking to and providing flyers advertising [our] services to local Wellington GPs.
- Podiatrists generally work closely with other health professionals including GPs and nurses. [Our organisation] encourages inter-disciplinary workplaces (where health professionals work together and share notes) rather than multi-disciplinary centres,

which basically allow those present to share rent costs and admin overheads. Often there is little sharing of information in a multi-disciplinary environment.

- Primary Mental Health Initiative.
- Provision of shared care. Advocacy and support for terminally ill patients.
- Regular for us is about once every two months.
- Some contact. We would like much more. (Particularly more frequent screening for problem gambling and referrals).
- Some GPs are very good collaborators.
- Staff flu vac. Overall care of boarding students within the college.
- Sunflower month with St John enabled us to work collaboratively with medical centres to provide information to older people living independently in the community.
- The GP is the third arm of our organisation, e.g. there are nurse-led community services (local), smoking cessation services (regional) – both are located in the same building as another organisation that provides social services, including an early childhood centre. The GP is located next door in another building. Referrals are sent from the GP/s to Community Services, acknowledged, and the referral allocated to the most appropriate staff member (e.g. a Tongan client to a Tongan nurse or health worker). There is a 48-hour return for the staff member to find the client, act on the referral including an assessment, a plan agreed to with the client, and feedback to the GP. Clients are referred also for further assessments and education by Nurse Specialists who work with Community Services or to the Smoking Cessation team to help people quit. For very serious cases, a doctor/nurse team will visit a client, although this is rare.
- The integrated family health centre model is currently being shaped – early consultation phase with community and providers in the DHB region.
- The medical systems rurally are like snappers a=x2; water tight and won't let you in any way – they think that they are the only professionals on earth.
- The most effective primary health service that we work with is the Te Aro homeless people Outreach Nurse in Wellington. We have regular reactive contact with her in referring people to her and receiving referrals from her. We also work closely with the Inner City Project of Newtown Union Health to access primary and secondary mental health support for our service users in temporary housing/homeless. We have very little referrals or working relationships with other GPs/medical centres, despite advertising our family/whānau services to them and referring to them regularly. We find that GPs/medical centres focus on the person in front of them as individuals and don't think about them being informed and supported as family members.
- This activity is mainly through the Psych. services and often when clients are referred to other services, e.g. for admission to general hospitals for medical treatment. A recent example is a long-term in-patient awaiting surgery, but in great agitation (fearing death). We made contact with medical and other staff on her behalf. This is really in a secondary/hospital setting.
- This is done by our Field Officer and is confidential between her and the client.
- Too large an area to respond in detail.
- Until recently we had an outreach clinic based in a medical centre.

- Usually working with the individual, the GP and then who they refer to and feedback. Sometimes upon discharge, the client will visit the GP and they have had no knowledge of what has happened. We see ourselves as the link between the services like ACC, GPs, WINZ and DHBs.
- We are a GP/medical centre!
- We are a GP clinic providing primary care.
- We are a primary care centre that includes GPs.
- We are aiming to increase our participation with GPs to mutually benefit people with dementia and their families.
- We are based at both Burwood hospital and the Auckland Spinal rehabilitation unit, and referrals come directly from the hospital staff.
- We are based in some GP clinics across the area. We work closely with NIR and the Outreach team.
- We are currently working with general practitioners to implement an annual health assessment tool for the people we support. People with an intellectual disability experience chronic mental health conditions three to four times more than the general population and have higher-than-normal rates of hearing impairment, skin disorders and gastro-oesophageal disease. The poor health outcomes for this population are related to unrecognised or poorly-managed health conditions and diseases, inadequate or non-existent health screening and ineffective communication between the individual, their family, whānau, support workers and the GP. There is also a lack of training and support for GPs for this speciality and due to poorly-documented medical histories, GPs rely on support people to inform them of areas of concern. Both GPs and support people are also reluctant to suggest people with intellectual disabilities have breast exams and pap smears (*Lennox et al, 1997*). Working with GPs to implement a proven annual health assessment tool will begin to improve the poor health outcomes. Unfortunately some GPs appear to be reluctant and impatient to complete annual health assessments despite their time being booked and paid for, as they feel it isn't a good use of their time when they could be seeing other patients.
- We are independent.
- We are self-supporting by our own contributions.
- We are a GP/medical service.
- We attempt to work collaboratively with all GPs and medical centres by providing them with information handouts to their patients, provide in-service professional development for the practice nurses and other staff members. We do get some referrals from GPs, but I feel this could be vastly improved for the benefit of patients, their families/whānau.
- We do occasionally get referrals/requests for information from GPs and medical centres. As renal services are a tertiary service and most of our interactions/projects on behalf of clients involve working with renal services, our working relationship with GPs and other primary health services is limited – but could, and probably should, expand. Renal services are beginning to explore options of working with GP practices for the provision of dialysis services for stable patients in the community – and we expect to be part of that process. We do, at times, accompany patients to their GP or speak to their GP on their behalf and their request, such as when the GP clearly has a lack of understanding of

how kidney failure affects the patient – and if we had sufficient resource to employ more staff, we would certainly put more effort into educating primary health professionals.

- We do receive referrals from GPs, but not on a regular basis. All GPs and allied health services have a full information pack including a dvd about Post Polio.
- We don't work at all with GPs or medical centres, though midwives have been known to recommend to their clients that they join our coffee group, and there have been a few instances of people calling upon a midwife's recommendation to get information on homebirth.
- We find it VERY difficult to work with medical centres. Even with face-to-face visits outlining how we can help with the management/education for clients, we receive ZERO referrals from most GPs. We now choose to focus on generating self-referrals. Very, very frustrating.
- We have a partnership with a local GP for drug screening and free health service for youth in crises.
- We have assisted a nurse smear taker from an iwi provider by providing an alternative room with appropriate facilities to see clients. We work collaboratively with others through the Manawatu Sexual Health Network.
- We have had a long-term relationship with one medical centre, which operates a regular nurses clinic at one of our housing complexes.
- We have had a specific pamphlet written for GPs to help them recognise the needs of family carers , what they can do to support them and why they should support them. We would welcome a closer working relationship with general practice.
- We have initiated a series of Patient Medication Reviews, which have meant greater health information sharing with local GP's practises, input into an individual's care planning, demonstrated improved patient outcomes and better adherence and use of their medicines. Sometimes this has meant visiting the practice to liaise personally with nursing staff. We (pharmacy) are often "the first point of contact" for acutely ill patients accessing healthcare.
- We have left our brochures at medical centres so that their clients can have an option for using our childbirth education service.
- We have limited interaction with GP medical centres, not from want of trying on our behalf.
- We have provided smoking cessation training to practice staff. We have provided pamphlet-type information on heart conditions and heart health to GPs.
- We have struggled to establish good working relationships with GPs.
- We have struggled to get consistent referrals from GPs. We continue to advocate for lower cost access for our community. Many GPs in this area are closed for new enrolments. MANY people do not visit GP due to cost. We are very like a health/well-being integrated family health centre.
- We have very little interaction with GPs/medical centres. The referral rate from GPs is very low to virtually non-existent. We write to GPs re mutual clients, provide brochures for waiting rooms and would be happy to work more closely with them but to date, this door has remained closed.

- We initiated an annual event for all GPs, community and other nurses to come together and share over refreshments, issues etc they may be facing. This has been very useful and has made our interaction a lot stronger out there for our community.
- We keep in touch with the district health nurses and local doctors who make referrals to our day care service. It's a mutual relationship.
- We mail information to GP clinics once per year.
- We make sure that GPs and medical centres are aware of us and have our details, so that they can refer bereaved parents to us.
- We occasionally refer women to GP services. Rare to get referrals from GPs but do from the practice nurses, Plunket nurses, midwives, DHB mental health services.
- We often refer our clients to their GPs as a starting point when they think a family member may be developing or has a mental illness. We also refer to the liaison nurse at medical centres. Our organisation receives very good response from the liaison nurses. We talk with the GP nurses about the services we provide. Our referrals mainly come from secondary services.
- We provide advice and education to practice nurses regarding asthma management. We work with a local DHB primary/secondary care initiative. We work collaboratively with primary and secondary care nurses to organise respiratory education for health professionals and awareness-raising activities.
- We provide nursing and GP services, so question not applicable to us.
- We provide sexual health education and updates on changing trends to GPs and practice nurses, and provide phone advice regarding patient management as necessary to all community agencies.
- We provide training. We bring international specialists to the Otago and Southland area to take lectures on the latest research, treatments and how to diagnose ME/CFS, and work with the GP training points systems. We send pamphlets and GP booklets to GPs and specialists in the above areas. We have some GPs and GP specialists refer patients and vice versa. We have provided DVDs of these lectures to some GPs and specialists who could not come to the meetings.
- We receive regular referrals from 2 GP practices in the district and occasionally from 2 others. All the referrals are a result of our relationship with their practice nurses.
- We refer clients, who have made us their first contact, to their GPs for a diagnosis.
- We refer our clients to these services, and we help clients to negotiate payment for doctors' bill arrears and/or set up accounts with GP practices so clients can afford to take their whānau when sick.
- We refer people to their GP/other medical services, but do not make official referrals. This is something for our family support workers to answer – I have referred the extra link you sent through to them.
- We regularly liaise with health practices, receiving and giving referrals. We also liaise with practice nurses re clients through the field worker role.
- We regularly receive referrals from one or two GPs, while there are dozens of others who could refer to us, but don't.

- We regularly support clients attending GP appointments when required. We accept referrals from GPs and practice nurses if clients may be at risk. We are currently involved with the PHO in the family violence screening project in GP practices.
- We sometimes, but not very often, receive referrals from GPs and medical centres – most often through practice nurses. We would like to work more closely with medical centres. From time-to-time we do send brochures and information concerning conferences and seminars on breastfeeding and related issues to medical centres and health professionals.
- We sometimes have to approach a GP to enable clients to access mental health services, as we are unable to elicit any response ourselves. We have even had to ask for assistance from the police to obtain help for them. We have worked alongside GPs to obtain specialist reports for clients to enable them to receive the best available rehabilitation. We need more GPs who understand the complexities of head injury, as many of ours do not have the necessary knowledge or the time to spend with clients.
- We suggest people go to their GP for allergy skin tests, gluten tests or RAST blood tests. We also advise them to see allergy specialists either privately or by a referral from their GP.
- We work closely with the GP of each patient.
- We work in conjunction with Waikato Hospital.
- We would like to see GPs using our services more to support people who need to access a variety of health and social services, but GPs do not seem interested in this at all, except when the predominant benefit is to them.
- We would love to have more involvement with GPs and med centres but struggle to get them interested in endometriosis or the work we do. We are currently wrapping up a major research project, which we wanted to involve GPs in, but could not find more than one GP to take an interest; with one GP saying they could not spare the half an hour to assist. The research project has found extraordinarily long delays with diagnostic delays, with many women expressing anger with GPs delaying referrals to the public hospital.
- We would visit GPs every few years to advise them of our services and drop off referral forms and brochures. For every referral we get from doctors, we do a written report back to the doctor of our findings.
- While we make many referrals to GPs, we rarely receive feedback, acknowledgement, or response. In more rural areas, the link with GPs/practice nurses is stronger, with some mutual interdependence.
- With each new referral we send a fax to the GP practice to notify the GP of our involvement and inform them as to specific services/programmes initiated.
- Work with a group of GP practices located within a specific geographic area to provide access to specialised aged care nursing assessment and case management. Improved working relationships between community nursing service and GP practices. Diabetes nurse specialists working alongside GP practices to support GPs and practice nurses to better manage patients with diabetes.
- Work with GPs in the Hornby area to refer patients to my clinic in Hornby. Also with medical centres in Rangiora to refer patients to my clinic in Rangiora. Work with other

medical centres (e.g. High Street Medical) to refer refugee patients to our services. All medical centres in Christchurch have been informed of our service.

- Worked with a collaborative group of consumers, primary care and secondary mental health service providers to develop information for people taking antipsychotic medication.
- Working with mental health brief intervention services.
- Working with the Primary Care Liaison Team for Older Persons to develop cognitive impairment pathway that would include referral to our service. Plan to talk with GPs re our role.

Comments from government bodies (e.g. DHB public health staff, MSD, etc)

- As I come from a DHB providing Mental Health Services, it makes sense to collaborate with GPs and primary healthcare organisations. In my role as a Nurse Educator a lot of the work we do is education and mental health awareness promotion. The biggest challenge for us is lack of education/knowledge from GP practices. This at times includes stigma and discrimination.
- Fax discharge summary for women who use our unit.
- I work in the area of diabetes and children's asthma. We hold regular clinics within most GP services. We often see the client with their GP/lead practice nurse. I take a physician (with a special interest in diabetes) out with us monthly to the GP practice to see complex patients. He also networks/involves the GPs with the patient consultation. We are currently part of the working group 'Tehei Wairarapa' planning Chronic Care Pathways.
- Initial project work focuses on psychology assessments and intervention, smoothing the pathway to and from Māori PHO. Plans in place to work collaboratively in AOD/co-existing disorders and metabolic monitoring.
- Management of patients who are homeless and have no GPs. Our links with GPs tend to be confined to referral in and out of our department.
- My organisation works closely with GPs/medical centres to understand how client's health needs affect their capacity to work and to establish client's access to appropriate income and allowances to access health and disability needs.
- Primary mental health integration.
- Project with Harbour Health. Gerontology Nursing Service. Collaborating with Whānau Ora House, Henderson. Helensville staff work closely as a health centre.
- Requests for information tend to be one-way, (i.e. from me to the practices, which means that GPs may not always get information that they need because they don't bother to ask.) GPs not always willing to accept information from other health providers to improve the care that a client is getting. GPs usually willing to furnish details requested about clients.
- This area could be improved on. We get many people through. One GP had done everything: recent bloods, X-rays, Echo – the patient just needed to see an anaesthetist. GP was fantastic, from Kapiti Coast. Wish more could do this. This was primary health care working well. Also sad when GP could have referred a patient, or has been asked by

the patient if they could send a referral, and the GP has said “No”. I do not understand this.

- We fund any projects that involved close collaborative activities between primary care providers and between primary and secondary services.
- We regularly receive referrals from GP practices requesting specialist advice, and we regularly contact these services about their referrals. We consistently promote the liaison between our DHB community staff and GP practices to ensure that there are as few barriers to the patient pathway as possible. Timeliness and comprehensive input with clear rationale for referral, assessment, outcome etc is really important to both primary/secondary providers and to the patients. We (DHB) have made deliberate attempts to develop an education package around clozapine in preparation for these clients who are stable and well on this med to be transferred back to GP care. This has largely been a nursing-led initiative and is progressing slowly, but quite well on a case-by-case basis. We are also about to start to look at primary-secondary interface within MH&AS in order to see what we can do to improve this interface. Preliminary meetings with key players with PHO have been had.
- We use a case conference approach with client families, and GPs attend these meetings on occasion to discuss health needs /plans for the family.
- Working with the group of agencies that are working with a family in the best way to help them move forward. This includes working with their GPs.

Comments from commercial providers (e.g. private practice, specialists, etc)

- Have GP clinic on plant.
- My Auckland, Wellington, and Tauranga clinics are based in medical centres. Other clinics are in separate venues. I have a strong relationship with ProCare PHO in Auckland, and some relationship with Pegasus PHO in Christchurch.
- One incidence of direct collaboration with GP when a client was at risk of taking an overdose. The GP was advised that the medication the client planned to use for the overdose was taken from him; the matter discussed and a collaborative decision was made that treatment should not be with pharmaceutical medication.
- Our training and education service over the past 15 years has been based on GP/practice nurse/primary health professionals and others working in the community accessing the programme via various means. Ongoing interlinks have been essential for our service provision.
- Provision of interpreting services.
- Refer with health issues identified prior to employment and do health-related testing prior to employment (e.g. audiometry and drug testing).
- Referrals are made to GPs but not a particular centre or a GP. It is regularly suggested that clients review medication with their GP, or seek further tests if that is a more cost-effective way to have tests/investigations done.
- Since my clinic relocated about a year ago, I mailed GPs in the area to advise of my hypnotherapy practice, and to explain about the types of issues where this modality can

be effective. I received no direct feedback from this, however I have received referrals from time-to-time from GPs who were contacted.

- We are a general practice, but we also take referrals for smoking cessation from the community and hospital for non-enrolled patients.
- We are currently involved in a joint project with the local marae-based, nurse-led health clinic – this is to follow up our enrolled Māori patients for CVDRA and reviews. We are part of a collective group looking at integrating general practices across two rural communities.
- We have begun a campaign to work more co-operatively with GPs. The first stage of this campaign has been to send all GPs in our area, a letter outlining our services and our philosophies for treatment within our scope of practice.
- We occasionally make referrals to GPs/medical centres. We occasionally receive referrals from GPs/medical centres.
- We used to have a close relationship with other GP services in Invercargill – shared education etc. But the merging of Otago/Southland PHOs has resulted in fragmentation, lack of nursing leadership, no primary health care education and a lack of perception of support.
- We welcome the move towards building integrated health services in the community.



Relationships with PHOs

5. RELATIONSHIPS WITH PHOs – As at July 2011, there are 32 primary health organisations (PHOs) funded by district health boards to support the provision of essential primary health care services to enrolled PHO populations. A PHO provides services either directly or through its provider members. – Thinking about your RECENT relationships with PHOs, please tick all that apply to your organisation:

[Create Chart](#) [Download](#)

		Response Percent	Response Count
Our organisation is a provider member of a PHO		20.8%	64
We get invited to attend PHO Annual General Meetings		20.8%	64
We have attended a PHO Annual General Meeting in the past two years		14.0%	43
We receive updates and/or newsletters from PHO(s) informing us of their activities		36.7%	113
A PHO sought our input to service planning and direction-setting		18.2%	56
We provided input to a PHO's service planning and direction-setting		21.1%	65
We feel the PHO took notice of our input and respected our opinion/experience		18.5%	57
We initiated contact with a PHO to discuss ways to work together to assist the clients/consumers/patients we have in common		41.6%	128
A PHO initiated contact with us to discuss ways to work together to assist the clients/consumers/patients we have in common		22.1%	68
We never hear from PHOs and they have not responded to our approaches		14.3%	44
We don't think the PHO(s) in our area even know we exist		17.2%	53
We do not see any value in building relationships with PHOs		1.9%	6
We do not know which PHOs are active in the areas that we work in		10.7%	33
We have worked collaboratively on at least one project/initiative/pathway with a PHO		32.1%	99
Please specify any collaborative activities or provide brief details about your PHO relationships			129
		answered question	308

When invited to specify any collaborative activities or provide brief details about PHO relationships – the following comments were made:

- A lot of PHOs will be unfamiliar with our services, except for our involvement with the Sunflower month St John initiative and the occasional GP who refers patients to our service. We have a wide range of services that older patients would benefit from and it would be great to work more collaboratively with PHOs in our region through perhaps quarterly network meetings with practice managers or something similar.
- A nurse based at the CPHO has provided services as a relieving nurse smear taker. We have worked alongside the CPHO via the Manawatu Sexual Health Network, which meets at CPHO.
- Across the country all of the boxes can be ticked – situation is so different for each area, with no pattern as to why one PHO will be proactive and another disinterested. There is not a strong sense across the country that PHOs are actively engaged in the provider contracts – for this to be more equitable will require direction from DHB/Ministry. Three major PHO collaboration projects underway:
 1. as noted above have a collaborative project adding Gout to chronic care framework in Manaia – currently being evaluated.
 2. Also have moved one of our community-based workers into Nelson Bays PHO – we are funding this for 12 months while looking for a sustainable funding model.
 3. Have a contract with Central PHO to run ‘Living a Healthy Life’ (LHL) courses across Manawatu area, and support a train-the-trainers programme on self-management for chronic conditions On a smaller scale we run a number of LHL self-management programmes with and through PHOs We have worked with a number of GP/medical centres in client referral for clinics, seminars or courses.
- Although we work within an organisation that works closely with PHOs, we have very little contact with them.
- Attended some PHO-run information evenings held on youth suicide and self-harm.
- Being a Kaupapa Māori service provider and through initial Whānau Ora meetings had around the motu, our attempt to engage to participate has lacked response from the Whānau Ora forum organisers. It appears the main larger health organisation services (both mainstream and iwi-based) that have been elected onto the Whānau Ora process networks, lack or starve communication to the NGO sector. The PHO services appear to lack organised cohesion to collaborate with NGOs, as we the NGO have worked collectively to align our service directives to (what’s working, what’s not working, and what can we do to make it work within the budgets allocated via DHB contracts). Basically PHOs are still at its infancy to collaborate with co-existing service providers disillusioned with the term ‘double dipping’.
- But this has not been very successful. We have been advised that we cannot be a part of the local PHO, although we continue to try to work collaboratively.
- Echo Project with Starship, Whakatane Paediatric Team, Te Ao Hou PHO.
- Ensuring enrolment with Well Child provider. Paracetamol Poisoning Prevention Project.
- Establishing the NP service in a nurse-led clinic environment without a visiting GP. As NGO RNs in this environment, we are not classified as provider members. However, we

have fantastic support from our PHO and contracts via SIA funding for Healthy Lifestyle Clinics and for B4SC services.

- Evaluation of client pathways through primary mental health services.
- Field Officer is involved with PHO but not sure to what level.
- For families not enrolled on our Well Child database, we have a joint letter to families re their options and ensuring Well Child checks are completed by a nominated Well Child provider or the practice. NB: This is just with one practice that was a PHO, but is now part of the large PHO.
- Funding for Partnership Health community workers from PHOs.
- Have approached PHO to support women in our service; not able to do so for the issues raised as GPs gatekeepers of the funding needed.
- Have piloted a new collaborative service and collaborated on the proposal for a IFHC that was unsuccessful.
- Have worked with a social worker from Partnership Health to get funding for hearing aids for a client.
- Health and Disability Committee.
- HEHA activities. Reconfiguration of services.
- I am unsure.
- I have been invited to speak to the staff of our PHO and they have my details on their pamphlet. If a consumer contacts us by mistake instead of the PHO, and that has happened numerous times, I direct them to the correct place. I have notified that consumers sometimes muddle the information, especially the 'To be Heard Programme'.
- In the Hutt Valley, the PHO is well aware of our service, however a few in Wellington know who we are and in Porirua, Valley PHO – there is an understanding of sharing the client with assisted transport, depending on what appointment they are going to. This means that the PHO and our programme know what is going on with the client and make a shared plan on a desired outcome.
- In the past, the PHO has given funding towards a Healthy Lifestyles Expo, organised by the local HALO (Healthy Active Living Oamaru) network; and attended by many organisations, including NGOs, a health centre, CCS etc.
- In this area there is a Primary and Community provider arm of the DHB as an alternative to a PHO. When the PHO existed, we made approaches regarding collaboration, which were heard but rejected. Under the DHB management, events have demonstrated that there is absolutely no interest in collaboration with our NGO. However, on an individual nursing level there is effective liaison and collaboration.
- Involving PHOs and other health information providers in community health building initiatives.
- It is possible that our Chief Executive has had contact with PHOs at a senior level.
- It would be good to build a good working relationship with PHOs.
- Many podiatrists have contracts with PHOs. Usually, a contract is in place to provide services to people with particular conditions, such as people with diabetes. It would be helpful if there were one place we could go to, to communicate with all PHOs at one time.

- Mental health promotion around social problems – debt, gambling, alcohol. Mental Health Awareness Week.
- No recent collaborative activities. However one of the PHOs from the Hutt Valley came to a Prisoner Re-integration Network meeting I attend. That's the most recent contact I have had with a PHO; unless you count working together on the Hutt Family Violence Prevention Network as joint members of the working committee. The PHO on that is Hutt Union Community Health Services, which is the umbrella organisation for the facilitator of the network.
- No resource to explore any of this!
- None of the above.
- N/A – Not applicable. (2)
- Not really sure about this.
- Not sure.
- Ongoing development with a number of PHOs following our DHB invitation and discussions/meetings with Prof Nick Kates.
- Our contact is with individual GPs and their practices.
- Our current interest is to identify and support the development of health promotion in primary care.
- Our medical centres are part of a PHO but I am not aware of any individual initiatives/schemes etc that pertain to the elderly.
- Our organisation co-ordinates home help for clients assessed by our local PHO. Have worked with them to streamline procedures and update policies.
- Our PHO is aware that we exist. It does provide us with a very small amount of funding to provide counselling services.
- Our PHOs have recently been collapsed into the Eastern Bay of Plenty Alliance. We are a member of Te Ao Hou Trust, which is part of the EBOPA. Our contact with the PHO is via affiliation to another group, rather than directly.
- Partnership Health Canterbury are a wonderful champion of what we do, they assist me in so many ways.
- PHO approached about the organisation's new Advance Care Planning process – no response. PHO approached about use of palliative care funding to improve provision of services for older people – negative response (after prompting). We get no direct communication from the PHO.
- PHO contact is controlled by them, they often don't respond to our questions. The contact we have is under their terms – usually means we have to be involved in one of their projects, otherwise be punished. No consultation before they initiate programmes – several which have had no value and have been withdrawn later.
- PHO funding for healthy eating/exercise programmes. Very poor relationship with local (Nelson Bays) PHO – only contact is ever initiated by us. Other than newsletters, absolutely no contact with this PHO. Have in the past offered invitations to meet, visit – no response. Now given up! Noticeable lack of relationship between PHOs and mental health NGOs, which seems strange given the Recovery model and the push to move consumers from tertiary through to primary care wherever possible.

- PHO initiated meeting with local GP representative on PHO to discuss GPs making referrals directly to our agencies (e.g. Parkinson's, Alzheimer's, Diabetes, Arthritis). We are all very concerned that we receive very few referrals from GPs. Since then the PHO has been changed and we have had no contact with them since. Hard to get GPs to make referrals even though our services can help improve quality of life for people.
- PHO sub-contracts us to provide some clinical services and a clinical advisor role. Three of our staff members sit on the PHO Clinical Governance. We work in partnership on health promotion activities (e.g. HPV awareness-raising for Pacific and refugee communities, Pacific cervical screening project.)
- Prior to the combining of all Otago and Southland PHOs into a single entity, we had very close contact with many different PHOs, both locally in Dunedin and in the surrounding rural area involving planning PHO services and education to providers. Unfortunately Southern PHO seems to think this is unnecessary.
- ProCare – establishment of three Whare Oranga.
- Referrals are made to PHO for most frequent services: miri miri, nutrition.
- Since the combining of PHOs, we have not had the same amount of contact with them and it appears that small community initiatives no longer happen with NGOs such as us. This is disappointing.
- Since the disbanding of Waikato PHO there appears to have been less interest in working with NGOs and collaboration opportunities. Focus appears to be on integrated family practices that are trying to be everything to everybody and are not inclusive.
- Some contact with PHO, but not a lot.
- Sometimes we are guest speakers.
- Supporting their Outreach Immunisation Programme by providing possible contact addresses for children/families lost to contact. Otherwise contact is minimal, despite being in the same DHB network meetings.
- The three PHOs in the district have recently combined so infrastructure is nearing completion and new relationships within the PHOs strategic and business plans are yet to be made public. Currently waiting for interim CEO to handover leadership to the new CEO coming from the UK.
- The familiarity of PHOs with our work varies from excellent to poor.
- The GAIHN is a PHO/DHB project.
- The GPs we are currently working with are members of the recently-formed PHOs through the Auckland GAIHN initiative. As many of the people we support are Māori, Pacific and Asian, we endeavour to link people with PHOs specialising in culture specific health care provision. Support worker feedback indicates that the primary health care provided by Whānau Ora and Pacific centres is more person-centred and cost effective than services provided by mainstream PHOs.
- The main collaboration was some years ago around services for people who are homeless with mental health and addiction issues. Recently, we have worked with a PHO in organising and running a local education/support programme for children of parents with mental health and addiction issues.
- The PHO arm of the DHB makes no contact with us currently.

- The PHO has recently restructured and now sits within the DHB structure, so we are waiting to see what happens! The PHO arm of the DHB makes no contact with us currently.
- The PHO may know we exist but we have very little contact unless they feel we have done something wrong. Communicating, collaborating or having any meaningful contact is challenging as it is difficult to understand their structures, hierarchy and who the right person to link with is. This is particularly the case for Partnership Health.
- The Stroke Pathway is going a long way in helping both parties to provide the best possible help to stroke survivors.
- There is no PHO in this area.
- These collaborative activities are mainly as part of Waitemata Stakeholder Network and a series of workstreams, which include PHOs in the Waitemata DHB region.
- Tihei Wairarapa Business Case.
- Unsure.
- We approached SECPHO about supporting a massage service for our refugee clients. This was funded for 6 months but then SECPHO was merged into WellHealth and has not continued. As stated above our relationships are with PHO provider members, rather than with the PHOs directly.
- We are currently involved with the PHO in the family violence screening project in GP practices.
- We are in the process of accrediting Māori and other NGO providers to the SPHO.
- We are one of the major service members of our small PHO.
- We are working with a group of PHO representatives that are looking into maternity care in Canterbury into the future. This includes members from many healthcare groups including the CDHB/ChCh Women's Hospital.
- We do however initiate contact with PHOs in the greater Auckland region, although this is in the early stages of development.
- We do not work in PH care. We do have some relationships with PHOs and work with them in relation to primary mental health on occasion.
- We find it very difficult to understand what the PHO is looking for and what services we could provide for them. We initiate 95% of contact with the PHO. We have no contact whatsoever with the Māori PHOs.
- We have 22 local organisations, some of which are in better contact with PHOs than others. We are wanting a more national approach in the future and are working on packages of information to assist PHOs to understand our services in the community.
- We have a problem that we work with a DHB and many different PHOs, and they do not get on – in fact, they are almost competitive with each other. We actually initiated a meeting between two PHOs and all they did was one-upmanship with each other, and no solution was reached regarding our working together. Since we have established ourselves as being a good service to the community, they deem to use us but it was not a good situation at the start. However they do not consider the problems we have with time issues and client distances as to getting people to appointments.

- We have a very supportive PHO who sees value in the services we provide for our clients. We assisted them to provide some updated education to practice nurses.
- We have asked a PHO to support us in a RFP; they were not particularly interested. We have started to try and liaise better with referrals. They don't make many our way.
- We have attempted to work with the PHOs, however we have found that they duplicate the functions that are already happening in the community, rather than work with the community. One PHO has set up a diabetes educator, asthma educator, a disabilities co-ordinator etc and all of these are pre-existing in the community and effective, and would have adapted and provided whatever was needed by the PHO, but the PHO has the \$\$ and, with no community interaction, announced their educators.
- We have dropped off brochures to the PHO office in Naenae. We have written to the DHB on a number of occasions advising them of the services we offer. We had a meeting with [a member of the DHB liaison team] in 2009 about the DHB funding a field officer for us – whose job it would be to assist rest homes and others with managing hearing aids for the elderly, but we never received any outcome of this meeting.
- We have lobbied the Government for years to recognise our needs and have had some sympathetic responses that have never come to anything. Our greatest need is a centre of excellence in the South Island to diagnose Post Polio problems. This service is available in Rotorua, but only to North Islanders.
- We have met with all three main PHOs in our area to discuss collaborative projects and how we can work together successfully, and these discussions and communications have continued.
- We have no relationships with PHOs.
- We have one trust that has established relationships with their local PHO.
- We have our own PHO. Māori health provider in Porirua.
- We have provided information and referrals to different PHOs. We have also provided training and information to staff around our service and the effects of problem gambling (PG) on the health of their clients, the vulnerabilities around PG, and other PG issues for their services.
- We have Service Level Agreements with 2 PHOs and an MOU with one PHO. We work collaboratively with these organisations.
- We have struggled to continue having services to improve access funding, which was ideal for our centre's activity and moved to an output-driven contract around smoking, diabetes awareness and falls prevention; which undermines our mission and success in connecting with people as a first stop in all health issues. Overall, our relationship to PHO is sound, but we don't feel we have certainty, status or fairness sometimes.
- We include the PHO sector in our networking day events and vice versa – more to do with health promotions.
- We know a community worker in the PHO.
- We know the local PHO and have met with 2-3 representatives re ways to work together. So far, the PHO seems bureaucratic and not very able to assist our clients (e.g. there is a huge demand for free counselling in the Nelson region, but this is very under-resourced; same with cervical screening, if it were free to all women or free to those with a Community Services Card, many more women would access it.)

- We make referrals to staff employed by our local rural-based PHO. We initiate discussions about roles concerning client/whānau/patient care. We receive regular training schedules from the central PHO in our DHB. We would like to be invited to give input in service planning and direction setting, because we believe that our role in primary health is not adequately understood.
- We provide consultation services to PHOs nationwide through regional smokefree networks, mostly during World Smokefree Day strategic planning, and via support in public relations/health promotion.
- We provide specific osteoporosis material.
- We share office accommodation with a PHO.
- We tried to initiate a memorandum of understanding with our local PHO with the aim of working collaboratively, but unable to achieve.
- We work as a support service to patients discharged from Waikato Hospital Cardiac wards.
- We work closely with the National Heart Foundation, but get practically no response from other PHOs in spite of all the flyers we have given out to doctors and pharmacists, also hospitals. After a very short period of time, we are again forgotten. We have certificates showing training undertaken to qualify the club, to help in advice and exercises.
- We would like a relationship.
- We would like to build relationship with PHOs nationwide to promote continence education. Main constraint is having only 1.5 paid positions in our organisation.
- We would value the opportunity to work with our local PHOs but all attempts to date have not been responded to.
- We would welcome with open arms the opportunity to work collaboratively with PHOs, GPs and medical centres. Our philosophy is that we each have areas of strength and working together could ensure that more families/people in the community receive a more holistic level of care, as we each contribute our part and work together – as opposed to separately.
- We write and send off to the Health Board, Performance Reviews about the service we provide and feedback from the customers/those attending our classes.
- Working collaboratively on several projects with 2 PHOs, a variety of primary care providers and secondary care.
- Working with Co-ordinator of Services for elderly and Very High Intensive User programme. General Manager on DHB Continence Steering group.
- World Smokefree Day collaboration. Smokefree coalition collaboration. We provided funding and planned a *Smoking affects lives* promotion storyboard that is permanently housed at a South Taranaki PHO.

Comments from government bodies (e.g. DHB public health staff, MSD, etc)

- As funder, there is a two-way relationship in working collaboratively to improve the health of our population. Our collaboration included a whole range of services in primary care.

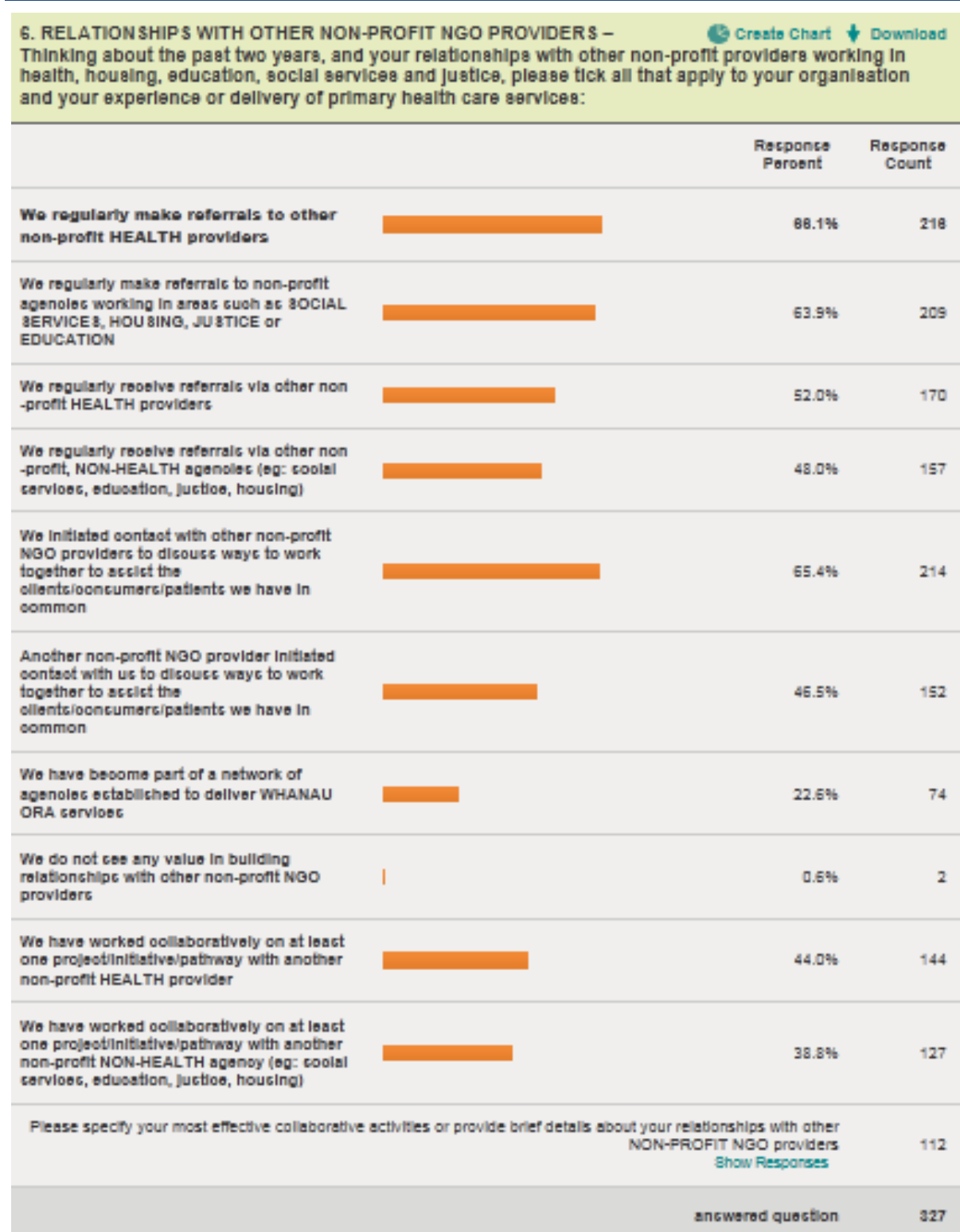
- Don't know.
- I expect that other people in the organisation have contacts/relationships with PHOs that I don't know about. I network with PHO staff to keep abreast of local health and disability issues and to seek ways to improve access to funding for health and disability services.
- I think that at mental health management level within the DHB, there is information about which PHOs, NGO, etc are working in the area, however there does appear to be a lack of clarity re who is actually providing what, how to access these providers, what their criteria is etc. As a clinician on the ground, this becomes very confusing and often leads to disengagement and a 'do-it-yourself' attitude. Greater transparency around these issues would enable services to work better together.
- I work alongside a PHO nurse at a weekly outreach clinic held in a lower socio-economic area. I have been part of launching a diabetes pilot programme for people with diabetes. The PHO assisted greatly with this – providing the venue and assisting with resource materials. The PHO invites me to any diabetes-related activities happening in the area. The PHO manager is present at all our local diabetes team meetings. We are involved with 'Tehei Wairarapa', planning long-term conditions pathways and initiatives.
- There is only one PHO on the West Coast – it is a waste of money as the majority of general practices are owned and operated by the DHB. A percentage of the money going to the PHO from the DHB is siphoned off for infrastructure and management of the PHO, when it could be better spent on providing patient care. We also duplicate some services. Some confusion is caused due to this. Health services on the Coast would be more efficient and cost effective if the PHO were disestablished.
- We established a specialist wound clinic in a PHO that provides services for the local population, regardless of their affiliation with the PHO.
- We have very little interaction with local PHOs. I have been attending 2 meetings with a local PHO to assist with setting up a pilot programme, but I was involved very late in the process and that information I was able to contribute was not included in their pilot plan. The pilot has not developed into a sustained service.
- We issue health professional advice to PHOs.

Comments from commercial providers (e.g. private practice, specialists, etc)

- Collaborative activities are with any PHOs that require training or cell group/website input relating to our training programme for their GPs or practice nurses. The PHOs now however seem to prefer short-term input through a variety of short-term funding arrangements, which is very unsatisfactory for long-term relationships.
- However our significant input into the Pegasus PHO has been largely overlooked in favour of DHB (and much more expensive) input. ProCare have been much more supportive, and I frequently support their education programme (on 'sleep' issues).
- I'm unsure that the PHO fully understands the services our organisation provides, and provides barriers to progression.
- In South Canterbury, we lost our PHO and now have a DHB division of Primary Care. I feel a great deal was lost when this occurred and we have not yet seen the improvements we were promised in the new arrangement.

- Our DHB-owned practices have been and are working with our PHO on several workstreams contributing to *'Better Sooner More Convenient'*, including Core General Practice Community and Allied Health, Frail Elderly, Mental Health, Improving Access to Diagnostics, Generic service specifications, among others.
- PHO not involved in community development projects so much, but important in things like free smear project.
- There has definitely been a loss of respect, trust and perceived level of support since the merger. What was once a welcoming office is now a skeleton of its former self. I have no idea who to call/contact if I have questions, need clinical guidance or support, have suggestions or complaints. Feel abandoned. I know they are aware that our practice exists, because they like to slam new performance targets onto us (which, from a coal face perspective, are bloody ridiculous and unachievable within the current system...but what would I know...I'm just working with the population and seeing the massive, glaringly obvious obstacles and barriers to effective primary health care services to those most vulnerable in our society!)
- They choose not to value the area of expertise that we provide.
- Together with the Christchurch PHO, we set up a Pilot Project from 1 April 2010 – 30 September 2011 to prove that the introduction of a skilled clinical co-ordinator into the pathway of care for people with Huntington's disease would positively influence their journey from diagnosis to death. We also proved that over the period of the project, by proactively managing these special patients with such complex needs in their own communities, we could keep people out of secondary health care, out of the acute mental health services and out of trouble with the police.
- We belong to a local community pharmacy group whose task it is to work with local PHO and DHB groups; however any interaction with the PHO has been very one-sided. As an independent pharmacy, the PHOs position has been unchanged since the PHOs inception – they appear to have no plan or desire to engage with us in any way.
- We currently do not have any strong working relationship with our local PHO, but would like to foster this in the future.
- We have only had contact with one PHO on a one-off funded project offering dietary services within the community. We already had three clinics in the community (2 of which were mobile clinics), and with the PHO initiative, we were able to put a 4th one into Aranui. When all the funding stopped, we had to reluctantly close these clinics. Then the earthquakes came and we were doubly glad that we had less overheads. Over the past 4 years, we have put in a terminal server to run MedTech remotely and can set up a clinic anywhere. We have also systemised our dietary services and have developed a licensing model for dietitians, which we are soon to launch nationwide. So we will not give up our efforts just yet to provide a way of reaching out to our community. Any help that the government can provide to do this would be really appreciated. We can assure best evidence-based practice, sound methods of tracking our patients and reporting. If we could offer our licensees access to funded programmes as well, then the movement of dietitians from secondary to primary care would be seamless.

Relationships with other non-profit NGO providers



Comments about effective collaborative activities and relationships with non-profit NGOs were:

- Across all areas we try to be aware of relevant providers for our client group. We have worked closely with GreyPower in the Wellington region to ensure clarity around the reassessment process, and to ensure, where possible, the needs of their group were met.

- Advice to members, help and advice from other sources.
- Again too large to comment across the country. In many areas there are good networks for health/disability groups, but this is not consistent. The role of PHOs in some of these is minimal from my observation. The Counties Manukau Gout Action Group is one example of a cross-disciplinary working group that includes DHB, PHOs, marae, Arthritis NZ, researchers, and has action outcomes.
- Age Concern, Alzheimer's Society and GreyPower all consulted regarding the Advance Care Planning implementation, and are consulted with regard to other matters involving resident well-being, when necessary.
- All NGO and DHB mental health services meet together monthly.
- Currently involved in a joint project with the local marae-based, nurse-led health clinic – this is to follow up our enrolled Māori patients for CVDRA and reviews.
- Because there is a crossover of fibromyalgia with those with ME/CFS, we have run 'coping with chronic illness' courses.
- Close collaboration with rape crisis, mirror counselling, youth services, schools and alternate education centres has improved referrals in both directions, and provision of education to both staff and clients.
- Cross referrals as needed; shared projects (e.g. workshops), new service to meet need recognised jointly; shared staff at pressure times; home-based support services; relief/respite care provided by local NGO, which sought funding so service is available to all.
- Face-to-face meetings with other NGO providers, either on a 1:1 or group basis as part of a wider organisation (e.g. Navigate – a northern region group of mental health and addictions service providers).
- For the last 26 years, we have been working collaboratively in the community. In the last year, we have held wellness days around the region. We do the planning and co-ordination and all NGOs are welcome to join us and promote their services – and they do. We have 12,000 people a year come through our centre. We help 30 groups monthly by letting them use our facilities and equipment.
- Health Expos, Road Safety courses for older people, Positive Ageing Forums, etc.
- I am a grassroots worker who knows little about the above questions. Too busy doing the job.
- I don't think I have worked with other non-profit providers, but would welcome the opportunity.
- I work in a school on a programme to build resiliency around problem gambling, alcohol and drug use. I attend meetings with other organisations for prisoner re-integration, family violence, Councils of Social Services. I am a trustee of a joint NGO, which runs a programme to build skills and social inclusion in a vulnerable community. I work collaboratively with other PG providers. I am involved with Work and Income Community Links in Naenae and Newtown. I work with other agencies and a PHO in Pomare on projects such as White Ribbon Day and *Christmas in da Hood* – a community-building Christmas event.
- If only we had the resource!

- In Hamilton there are lots of opportunities for networking amongst NGOs and we often refer clients between agencies.
- Incredible Years programmes, strengthening families meetings, meetings with other agencies etc.
- Lots of collaboration with training providers of health training: midwifery, nursing, medicine.
- Multiple examples exist, but one of note would be a community suicide prevention plan.
- N/A.
- Note: We do not deliver PRIMARY services but within the community setting we operate from, the above is true.
- Our field officer has contact with other health agencies, but as we are only a small group, not on a regular basis.
- [Our] field worker attends regular combined mental health network meetings, which are attended by many local organisations and has regular speakers, also through Work and Income. The field worker attends regular family violence meetings, focussed on strengthening families, which are attended by many local organisations. The field worker also attends Field Officer network meetings on a regular basis, attended by not-for-profit NGOs.
- Our main referrals are to and from other hospital chaplains. Some contact from churches, community groups and concerned family and friends.
- Our organisation is the only non-government provider of health services in our area.
- Palliative care patient support and advice, and education for patients and staff.
- Partnership with 2 other NGO providers to develop and run a peer-run (mental health) respite service in Marlborough. A very successful initiative. Generally strong relationships with other NGO providers across the region.
- Providers of medical alarms: they regularly update with us and we check with whānau and refer to the provider of their choice. National Arthritis Foundation: we had regular contact and referred clients to arthritis clinics until recently when the position became vacant/?disestablished.
- Public education is a collaborative effort between crisis agencies, police, public health and other health educators.
- Regular referrals to the palliative care team, and also wound care specialists from another NGO. Recent discussions with another NGO about provision of low-cost housing for older people. Previously have used expertise of another NGO in quality programmes for residential aged care.
- Setting up Stopping Violence hui, regional hui and training for facilitators.
- Sexually transmitted infection testing off site. Christchurch Pride week. We have a collective called the HIV/BBV (blood borne virus), which meets monthly to share what we are doing and seeing, and to do periodic collaborative projects.
- Snug homes. Te Whare Whakauu – Tuakau Whānau Resource Centre.
- Te Rangi Ohakune.
- The medical professionals dealing with our families will make such referrals.

- The service we provide in a rural area is in partnership with another NGO, in as much as we provide services to the carers of their clientele, and are accommodated in return in their offices.
- There was a very sad instance last year when a couple returned from overseas. The man was local, the woman Asian. When the man died after suffering a stroke, the woman was at a loss on how to deal with funeral, benefits, housing and a multitude of problems that were outside her experience. Our Field Officer assisted with these problems and also gave her some household things, curtains etc. She had nothing.
- This also occurs through the Manawatu Sexual Health Network. We network with other groups and share information and resources. We have assisted other NGO health providers through giving copies of our policies to assist them to develop theirs.
- Violence Free network. Family Violence Intervention group. Safer Wairarapa. Te Piringa (MH & AOD). Community Alcohol Action group.
- We all share the same client base regarding budgeting and counselling.
- [We are] a member of the Allied Health Professional Associations Forum (AHPAF), which meets every two months in Wellington.
- We are a part of the Carers Alliance raising the profile of carers in the community. We are also part of the Neurological Alliance where other organisations [working] with brain disorders work together to find solutions for people living in the community affected by these disorders.
- We are currently working with another NGO to promote men's health at a race day. We developed and funded the '*Smoking affects lives*' display board with another NGO. We have attended a number of community health and welfare promotional events with community law, MSD and other organisations present.
- We are currently working with two other not-for-profit organisations – both church-based – to look at ways we can provide consistent services. Currently we are developing consistent standards and processes. It is envisaged we will be able to support one another as demand for the types of services we provide increases with an ageing population.
- We are linked to all services in our district – they are an integral part of our service delivery.
- We are part of a Māori and Pacific Collective (four providers that are all non-profit NGOs).
- We are part of most of the NGO provider forums at a local level. They are very effective mechanisms for information sharing and feedback, particularly post-earthquake. We are specifically part of both older adult and disability provider forums in the NGO sector.
- We are part of our local Smokefree group running promotions and offering smoking cessation support to anyone in our community who wants it.
- We are part of the Carers Alliance (a group of 45+ NGOs). We work collaboratively on a range of issues that are important to the group. We also work with several members of the group that have issues with incontinence.
- We are part of the local non-profit health and non-health provider networks and work together on a client-by-client basis and on some other health promotion activities.

- We are very well-networked to all other health and social service agencies here, and our worker is constantly working within this context. One notable: Refugee Services bring their new refugees from Mangere when they arrive to our centre where they meet their volunteers and workers and then connect with this place as an ongoing support.
- We attend Elder Care Canterbury.
- We believe we have the potential to develop relationships with other providers.
- We collaborate on a regular basis. For example, a Family Fun Day (as part of Gamblefree Day on 3 September).
- We could tick the first 4 questions if the word ‘regularly’ were not used and ‘sometimes’ or ‘occasionally’ substituted. We have MOUs with other organisations that work with refugees. These are not health providers, but are providers of social work and community development. These relationships are very strong as we are housed in the same building and professionals relate to each other on a daily basis, and there are many joint projects on the go at any one time to benefit our common clients (refugees). We can modestly claim this is probably the best model of collaboration anywhere in NZ in any sector.
- We formed a collaborative of four organisations to tender for mental health and addiction services within the Wairarapa. We work collaboratively to produce a quarterly newsletter, updating news and views from the local mental health and addiction services. We work together on health promotion activities such as Mental Health Awareness Week.
- We frequently work in collaboration with other not-for-profit NGO organisations, but not concerning the health needs of individuals.
- We have been working effectively with KCHT (Kaipara Community Health Trust) Dargaville, since we established this service and have continued to have a good working relationship. We now have a better relationship with our DHB (Whangarei Hospital) as we offer a service to transport patients home and have initiated meetings with all the DHB social workers. This has enabled us to work smarter and more timely with the hospital discharge system.
- We have collaborations with 5 other NGOs in the areas of housing, community action, community activity, information and resource sharing.
- We have endeavoured to develop a one-stop-shop for people with disabilities, incorporating 5 other not-for-profit organisations. We share the one site and share common resources, as well as endeavouring to work collaboratively in the acquisition of additional resources. We are committed to exploring future collaborative endeavours, including a major building project that will purposely house all the current groups on site, as well as have additional capacity to include other like-minded groups. Our conversations explore ways that we can reduce individual organisation’s costs by pooling resources, shared common trainings of paid and unpaid staff, discussions at governance level on combined training and resourcing and seeking to define a common goal. Long-term, we envisage a common administration service and the possibility of shared employees (e.g. social workers). A co-ordinator of collaboration is key to our working together effectively, as is the building of relationships.
- We have Genesis Trust in our building – services to youth offending.
- We have had dealings with Pregnancy Help and La Leche League.

- We have informal relationships with other agencies that offer educational tools and resources to schools. We promote these tools and services to the schools when we are working with them and in our correspondence, where appropriate. We do have some MOUs established for more formal relationships.
- We have representatives sitting on the national tobacco control working group and regional smokefree networks to collaborate on the strategic planning for the tobacco control sector. We collaborated with other NGOs and non-NGOs in the sponsorship and planning of the *Tobacco Free Aotearoa Conference* in 2010. We have a representative on the PHA conference planning committee for 2012.
- We make significant effort to foster and maintain collaborative relationships with all NGOs in our area.
- We need to establish better ways to deliver Whānau Ora services. There is huge value in building relationships with other NGOs.
- We network and work with other women's health advocacy groups, community groups, etc, both locally and at a national level.
- We often share clients and so referrals go both ways. Many of our clients have co-morbidities.
- We provide services across the lifespan and link our enrolled population to the following, based on comprehensive health and whānau assessments and shared care plans. Mobile whānau ora nursing services: school-based, outreach clinics. Smoke free coalition networks. Social workers in schools networks. Kaupapa Māori drug and alcohol counselling services. Kaupapa Māori counselling services. Rongoa practitioner services. Tai Chi practitioners. WINZ re employment issues impacting on the whānau, food, heating etc. Iwi and urban marae nurse clinic project to deliver integrated nurse clinics on marae, and provide a suite of tools for marae to sustainably manage marae clinics, once pilot services established.
- We regularly make referrals/recommendations to people to look into Le Leche League (breastfeeding support group) – who I assume are non-profit.
- We regularly meet at local community forums to discuss and share information/resources/contacts.
- We run a bi-monthly network meeting at which representatives from organisations that provide services to older people in the community attend and share information. We work with other organisations (government and non-government) on our annual IDOP (International Day of the Older Person) events. We attend community health days and other community events. We attend all the local network meetings in our region (about 10 a month).
- We sometimes hold meetings in the CCS rooms.
- We work closely with the following to assist low-income families:
 - to get food (Salvation Army, Nelson Foodbank);
 - to get help paying winter power bills and other urgent basic expenses (Fifeshire Foundation, St. Vincent de Paul, Salvation Army);
 - to get assistance dealing with Work & Income (BUWT, which is the Beneficiaries & Unwaged Workers Trust);
 - to get help – with budgeting (Nelson Budget Service);

- to get emergency or rental housing or a loan for bond (Nelson Tasman Housing Trust);
 - to gain access to a low-cost medical service (Victory Community Health Centre);
 - for parenting and family support (Family Start, Te Korowai Trust, Barnardos);
 - for education and counselling re family violence (Stopping Violence Services);
 - for a women's safe house re family violence (Women's Refuge);
 - for Māori wanting to access kaupapa Māori services (Whakatu Marae, Te Kahui Hauora o Ngati Koata).
- We work collaboratively with a number of organisations to ensure people who access our services receive individualised and person-centred supports. We have established relationships with a number of disability providers, needs assessment agencies and the Health and Disability Commission. Relationships are also in place for a number of other organisations, such as the HeartBeat Challenge (Heart Foundation), learning organisations and community-based associations and trusts. We have recently entered into a collaborative agreement with another disability provider, and are sharing offices and other resources.
 - We work in collaboration with many other organisations to provide services: Strengthening Families, Barnardos, Salvation Army, St Vincent de Paul, Earthlink, Take 5 Te Whare Marama, Oasis Network, Downtown Community Ministry, Compassion Centre, Wellink, Q-nique, WINZ, CYF, Police, Te Roopu Awhina, other branches of Supporting Families in Mental Illness (of which we are one), all mental health service providers in the greater Wellington area.
 - We work with a number of NGOs – may include CAB, community centres, counselling and budgetary services, social groups, activity groups, Age Concern.
 - When we run training for staff, we invite other non-profit NGOs (i.e. Birthright), and we are invited to attend other NGO staff training (i.e. Pathways staff training – Pathways Model of Wellness). We invite other NGOs/iwi services to our education courses. We are currently working collaboratively with a consumer organisation in providing/sharing resources in the rural area. When we are aware of other NGOs working with a family/whānau, we invite them to a family group meeting. We would like to be part of a network of agencies established to deliver Whānau Ora services.
 - With limited resources and time, it is important to work collaboratively with other NGOs. A good example of this is setting up a monthly support group in a rural area. As neither of our organisations is able to physically facilitate this every month – we take turns, creating a win-win situation for all.
 - Worked with Te Whare Roimata to provide services for their consumers.
 - Working alongside the Salvation Army in Gore to find the best available services to enable a family in crisis to function better, is one example of working with other non-profit organisations.
 - Working in Community House, we have strong networking with other NGOs.
 - Working with another NGO to provide support to a mutual client to get better services from our PHO.
 - Working with iwi providers to ensure referral pathways for Māori clients are available/appropriate (i.e. for specific services such as violence prevention, whānau support). Iwi providers are working on Whānau Ora amongst their own iwi and have indicated we may be involved at a later date, when internal relationships are agreed.

- Wow, this is a big area. I find most NGOs are keen to work together, but there are some barriers if they are providing a service similar to yours – they want to do what we are doing themselves, so sort of a duplication of services. Even if the service is our speciality, they need to use us more and concentrate on what their speciality is. You see you are talking job losses possibly, if they let go and let other NGOs do what they are doing.
- Youth service counselling services within the region (i.e. VIBE, Skylight).

Comments from government bodies (e.g. DHB public health staff, MSD, etc)

- Again, working as one with a family, rather than all working in isolation.
- CYF can work well. School can work well – depends on teacher and principal. RAS can work well. In a nutshell, it depends on individual clinicians and workers on either end, and how much of an expectation their managers have that collaboration is the way forward. It is highly variable.
- I also work in the area of children’s asthma and diabetes. I have referrals from the Asthma Society to visit families to assist with asthma management. I work with the local Asthma Society and Diabetes Society who sponsor children with asthma to the *Learn and Live* camp for 1 week of the school holidays. I am a volunteer nurse at the *Learn and Live* camp 1 week of each school holiday and this is the week children with asthma/diabetes attend, so that asthma/diabetes education is part of everyday activities. I have educated the Camp directors on asthma management should they have a child with an episode in my absence. Diabetes Wairarapa also funds children to national camps, which I also attend as a nurse. I work with the Plunket/Idea Services/local schools/Open Home Foundation and Turrent House regarding children they are caring for, to better manage their asthma/diabetes and assisting them to camp. I have worked with our local Lions and Lionesses to get sponsorship for people (mainly children) with diabetes to fund them insulin pumps. This has made a marvellous difference to their health and well-being. Variety Children's Charities have also funded 2 of our children with insulin pumps. Diabetes Wairarapa has also acquired funding, which they have used to buy insulin pumps for local children and youth aged 21 and under. I refer clients to ‘healthy homes’ for home insulation and heat pump installation. I refer clients to Salvation Army for clothing, furniture bedding and food. I work in collaboration with mental health services, Richmond Fellowship. We do a multi-disciplinary clinic at Papawai Marae monthly, often taking a doctor and podiatrist. I hold a 2-weekly clinic at Whaiora Whanui (Māori Health unit). I am a regular speaker at the Ngai Kahunganunu ‘Healthy Whānau’ groups.
- I personally have a close relationship with the Parkinson's Disease Society – we assist each other to provide a quality service to our clients.
- My organisation has relationships with social services, housing, justice and education. The organisation has links with justice to provide better health and income services to prisoners re-integrating into their communities.
- Our most effective collaboration is not with any NGO but with the Canterbury DHB – this is a recent initiative and I see the benefits already, and it will continue to improve.
- Our non-health projects included:
HEHA: healthy eating, healthy action programme with churches, schools and several NGOs
PATH: a pathway to access health intervention to facilitate return to

work/education/training

CART: programme for 'hard to reach' sub-population with strong involvements with Ministries of Justice, Labour, Education, Internal Affairs and Te Puni Kokiri etc...

- Our referrals to these services are made through hospital social workers.
- The purpose of Strengthening Families is to join families and the agencies they work with together for a meeting to create a shared service plan. The plan is reviewed later. Many NGOs and government health, education and social services make referrals to our programme, and professionals from those organisations are involved in our planning meetings for families. We also have Local Management Groups throughout the country, made up of the managers of government agencies and some NGO managers. These groups oversee the operation of the programme in their local area, and have a responsibility to support effective collaboration between local services.
- Warm safe healthy babies session in collaboration with local council advisor for Warm Up NZ – home insulation.
- We regularly invite other providers to come and present their team or their service to us for an hour, usually on a Wednesday. We will invite two services to come to us and then we ask those services if we could go to them and present our service. I usually look for opportunity to promote our service. Recently we had a stall at the Pacific Youth Expo in Porirua. I usually ring other services to ask if we could go and talk to them about our service etc. We normally get invited by the church to do a presentation on family violence and parenting programmes we are running for Pacific parents called *Incredible Years*.
- We regularly work with NGOs that provide services for MH&AS clients. This often involves working/liasing with social services (i.e. WINZ, justice etc). We attend our local POL 400 meeting, which is a meeting of police, CYFS, probation, etc and are able to liaise around joint clients.
- We work with a Whānau Ora provider.

Comments from commercial providers (e.g. private practice, specialists, etc)

- I have been asked to speak to organisations (?NGOs) of all sorts, about sleep/shiftwork issues.
- Making a simple phone call and offering ourselves as logistical support, i.e. access to necessary equipment that we can access, but that they cannot (such as fundamentals like free spacers, educational material and resources).
- Screening for drug use prior to employment.
- We assist in the establishment and maintenance of quality medication services within NGO residential care facilities and assisted housing initiatives.
- We occasionally make referrals to other non-profit HEALTH providers.
- We would like a more collaborative approach from other counselling providers. Especially those who provide 'free' counselling. We'd like to be included as a counselling centre that provides 'free' counselling.
- While we would love to work with non-profit organisations, this only works for us if community funding is provided as someone still has to pay for the rent and reception.

Other relationships

This free text question gained the following insights about other relationships that benefit clients/consumers/patients:

- 1. Psychologists/psychotherapists/counsellors; 2. Education settings/Alternative education; 3. Marae; 4. Pacific churches; 5. Community centres; 6. Sport agencies; 7. A wide range of community NGOs; 8. Pharmacies; 9. Dietitian; 10. Tai Chi providers; 11. DHB services health and mental health.
- Able to share information about other service providers. Able to reassure (or otherwise) whānau about other services.
- Actively working to improve working relationships with pharmacists and with other health agencies. Part of a providers group that meets regularly to share and discuss issues and ideas.
- All health and disability service providers receive a visit from me (usually annually), and I give out pamphlets and discuss what is on top for them.
- Allied Health at the hospital – equipment and physio. FOCUS – personal care and home management assessments. Arthritis Foundation – exercise.
- Allied health providers: pharmacies, nutritionists, rongoa Māori, physiotherapists; high schools, kohanga reo, primary schools, wharekura, local businesses, government agencies health, welfare, housing, fisheries, iwi governance boards.
- Also accredited as Approved Assessors for Hearing Assistive Technology (HAT).
- Any organisation that is funded to deliver services.
- Audiologists.
- Being a NFP organisation we have many relationships with allied health providers, including pharmacies, nutritionists, speech and language therapists, OTs, massage therapists and physiotherapists, plus with commercial businesses through sponsorship and donations. Many of the allied health providers give their time and knowledge for free or at reduced charge as a donation to hospice. Without this, we would not necessarily afford these services for our clients due to the way our contract with the DHB is written and interpreted. There are concerns that a client can get a funded drug or treatment if they receive it at a DHB hospital. The same drug or treatment, if given at a hospice, is part-funded by donations as, with the rise in palliative treatments being rightly available to palliative clients, then there is a general expectation from the DHB that hospice will absorb these extra costs without cost analysis or increase in an individual client's funding. I do wonder if each client should be costed rather than a blanket amount with a cap on client numbers by the DHB. Currently hospice doesn't turn people away because we are above the cap – with the increase in services the DHBs are looking for from NFP organisations, it may become a reality.
- By being well-informed about the services available, so that we can refer on if we are unable to provide the service that is required.
- CMDHB, ARHOP, NASC, Alzheimer's, St John, BUPA, NZ Fire Service, WINZ Senior Services, Housing for the Elderly, Auckland Council Community Advisors, Grey Power, Mental Health services for Older People, NZ Police, Salvation Army and many others.

- Collaboration with pharmacies around patient's medications when there are discrepancies in scripts, or we are unable to do a script and they need to borrow some meds to tide them over. We refer to physios, often as a first point of contact when applicable to save patients time and money.
- Community pharmacist: Expert advice and education in developing our medication policies
Allied Health: Have our own in-house, and also work with secondary and community care AHP
Wellington Free: Developing shared services for out-of-hour callers.
Voluntary agencies: Work closely with voluntary and charitable agencies locally.
- Department of Corrections: We have a pilot project, Whare Oranga Ake, to assist in the reintegration of male prisoners back into their whānau, community and employment settings.
Ministry of Education: To provide an early education centre primarily for Māori, Pacific and 'Other' mothers first time or multiple children, who have high risk needs.
We have access to the PHO-funded community nutritionist, pharmacists and diabetes nurse specialist to our enrolled population for 1-1 or in focus groups.
- DHB services. Homecare agencies. RNZFB. Having strong network connections builds a safer and stronger environment for an older person to live in and will improve their well-being.
- Dietitians. Podiatrists. Retinal screening. Pharmacists. Massage therapists. Māori healers. Physiotherapists. Naturopath. CYF. HDC.
- District Health Board (s) – Justice – WINZ – Housing NZ – Social Services – Marae 'me ona Tikanga' Kaumatua Kuia forums Whānau forums – Whānau Advocacy services – Local Council(s) – Civil Defence, Fire, evacuation services and local communities – Community mental health services – Psychiatric Drs, nurses, pharmacies, Inpatient Units, AOD, OT services – Community mental health social workers – Regional Co-ordination Services – Provider Arm Services – Hospital Emergency Medical/Clinical services – Mental Health Crisis teams – NGO Activity programme services – Employment Agencies – Alternative Māori models of health and therapy services – Legal, accounting and auditing services – Mental health District Inspector – Nominated church services – Red Cross and Salvation Army services – NZ Police – St John Ambulance – Ministry of Health (Commission) – Poly-Tech – Kura Wananga – Māori Land Court.
- Federated Farmers – rural mental health. Taranaki Rural Support Trust – rural mental health services. Dairy NZ – working party. Ag Research – another working party. Min of Ag & Forestry – contracts to provide services. Dairy Women NZ – same as above. ALL Support services and accommodation – we facilitate regular meetings of the mental health sector. TDHB MH & A Services – 4 senior managers are on our Trust. City and Regional Councils, Housing, MSD/W&I, ACC etc. Funding organisations – TET, TSB, APEPSI Trust, etc. Private funding organisations – businesses that support our work. Local community service groups – Rotary and Lions. Settlement Support Advisory Board NGO Networking group. Supporting Families, Positive Ageing Trust, Suicide Prevention Co-ordinating Committee, Supported Employment Network, etc, etc.
- Government agencies.

- Guest speakers from other professions (e.g. midwifery, physio, naturopath, child psychologist). Practical support from local church group (e.g. meals, working bees in client's homes, gardens'.)
- Have an intensive relationship with WINZ and NASC.
- Health Care Aotearoa, Māori Health Outcomes Group, Landbase Training, Local College, Alternative Education, Local District Council.
- Hei Hei Community Centre, Bromley Community Centre, Bishopdale Community Centre.
- Hospital Physiotherapy Departments, Haemophilia Treatment Centres.
- Hospital wards/departments and DHB staff (e.g. community physios, nutritionists, clinical nurse specialists, medical specialists.)
- I do work with various social workers from various hospitals when they refer their clients through, but there is nothing available where we would build that relationship. A lot of my referrals would be to a GP or neurologist, then maybe community-based organisations like Volunteer Canterbury, budget advice, 40+, and also govt depts: WINZ, Workbridge and Job Connect.
- I have a relationship with the audiologists in the area.
- In our presentations on mental health issues, we have invited mental health professionals to participate as presenters to service-users and their families. This has helped to increase an awareness of managing clinical issues.
- In the Southland DHB area, we have a formally-organised and co-ordinated community network forum. This is called Future Directions. It very successfully provides a co-ordinated, integrated network of groups and individuals who work in the areas of health and social services. Many are small trusts, some are NGOs and some are fully DHB-funded.
- Just establishing that we are here has been hard enough. It seems that many people in primary health care do not think of us as of much importance, but we have now gained a reputation in our community and relationships have been better in recent times. It appears to be that we were looked upon as a fly-by-night service, and have had to fight to be given the credit we feel we deserve.
- Local Council Housing, Law Centres, DHB, Pharmacists, Physios NZ Nutrition Foundation, Alzheimer's Auckland, Arthritis, Mental Health, Council of Social Services, housing groups, Sport North Harbour, Green prescription, community co-ordinators, libraries.
- Local iwi trusts and marae, sporting groups, churches, St John, local council, local clubs, community groups (e.g. care and craft, Sherwood club – Alzheimer's Society).
- Local pharmacies, Māori provider, NASC, district nurses.
- Local pharmacy. Local physiotherapist – refer and can be provided with prompt appointment for students if needed. Provides sound advice re sports injuries. MOH, ACC, ALAC.
- Local pharmacy, mental health clinic, AOD clinic, PHO counselling service providers, family court counselling, Lifeline, women's support services, independent nursing practice, midwives, Bowen therapy volunteer therapist, osteopath, physiotherapist, and a range of alternative health practitioners, such as acupuncture, chiropractors etc. We would refer on wherever possible to those with whom we have established relationships

in the first instance, but being a relatively small city, would also support connections to those we are not so familiar with, but can check out.

- Massage therapist, nutritionists, hearing clinic, pharmacies, Presbyterian Support, Arthritis.
- Member agency of a range of sector networks – e.g. Right Service Right Time, Strengthening Families Local Management Group, PHO Services to Improve Access to primary care, Settlement Interagency network, CDHB CALD Advisory Committee, Elder Care Forum and others. The networks are established to ensure accessible, timely, relevant service delivery to all clients/consumers, from our point of view, with a particular emphasis on culturally and linguistically diverse people.
- Ministry of Social Development answer 0800 Power to Protect Line.
- Most all other local businesses and health providers whom our clients need to access, all of the above. We have knowledge of the role organisations have in our area/region due to our MSD contract to provide information and advocacy and we also have input to this sector only if people require and advocate.
- MSD, MOH, MOE, MOJ, TPK, Genesis Energy, Solid Energy, HEET, Huntly College, Ngaruawahia College, Raglan Area School, Te Kauwhata College, primary and intermediate schools in North Waikato.
- Multiple: Optometrists for retinal screening for diabetes. Refugee support agencies: Refugees as Survivors, RMS. Well Child services, Plunket, Mental Health Support Services; supported accommodation, primary care mental health initiative, secondary care services, Social Welfare. We have massage therapists, student dietitians, podiatrist working from our clinic. Close working relationships with several local pharmacies. Close relationships with several secondary care services, clinics run out of our place by psychiatrist, diabetes specialist, child development specialist (obstetrician in the past). As noted above, we have many different students in the practice, undergraduate and postgraduate in medicine, midwifery, nursing, dietetics.
- N/A.
- NGO mental health providers, pharmacies, WINZ, Police, Housing NZ.
- No-one wants to know us. We are successful in what we do and that's the crust for our society. Hard as rocks.
- Nutritionists, podiatrists give their time to 3x Whare Oranga.
- One relationship that is important to us is with our local DHB. In our situation they provide a small amount of our funding, but they are also a good source of referrals for us – as we are to them. The relationship has evolved to the stage that we are invited to participate in the discussion and development of new initiatives and there is a more collaborative approach being embarked upon, as we recognise that partnership is the way to continue our service provision to a wider range and number of people on a limited budget.
- Only if referred by the GP. Mostly to physios.
- Otago Polytechnic, Otago University (Pharmacy Department,) Sport Otago.
- Other relationships for our service are with Justice Department, AOD Services, Mental Health Services, psychiatrists and physiotherapists..... We attend appointments with families/whānau when they meet with psychiatrists for a family meeting, support

family/whānau at Court hearings/lawyers meetings (relevant to mental health issues), attend Family Group Meetings at CYPS and Strengthening Families Meetings. The benefit for our clients is that they are able to debrief after the meetings to gain a full understanding of the meeting, we are able to assist them to be heard, advocating for them if they are not receiving the information they are seeking.

- Our clients benefit from our ability to liaise between multiple service providers to ensure they get all their needs met. We can offer referrals to counselling services, budget advisory services, GPs and have an understanding of the complexities of the secondary services provided.
- Our only access to health providers is through our partnership with a local GP.
- Our other most significant collaborative relationships are with WINZ, CYFS and HNZ. These relationships benefit our clients as we advocate and support for/with them with those government agencies.
- Our stakeholders cover a wide range of services from Early Childhood Education, Paediatric hospital services, midwives, social services such as Birthright and Family Works, Child Youth and Family, Māori providers etc. Having a positive working relationship with all these services allows us to refer our clients so they can access the services they need.
- Our working relationships with crisis agencies, protection services, police and GPs provide our clients with a seamless service and continuity of care.
- [Our youth service] takes a collaborative approach with existing services to provide effective interventions and support for the young people who access [us] within the community. [We] have close linkages with many organisations within the community. Many organisations struggle to find appropriate services that young people will engage with, however young people connect easily with [us].
 - Working partnerships and meetings with: Child Adolescent Mental Health services, Early Intervention Service, Adult mental health services, Te Whare Marie mental health services, CYFS Youth Justice Social worker, Frontline workers meeting, Youth Workers Network, Voices against violence, Youth One-stop-shop Network (Vibe, Evolve).
 - Referrals and Liaison: Barnardos, Plunket, Birthright, Midwives, PHO.
 - Work closely to implement programmes: Our Peer Support Workers with [local] district council's Youth Council.
 - Organise initiatives within district: Regional Public Health, Safer Community Trust, Police Youth Aid, WINZ Work Brokers, Health & Disability co-ordinator, CYFS, Hora Te Pai, Youth Quest.
 - Strong Relationships: Local secondary schools including guidance counsellors, RTL, GSE attend interagency meetings at the schools, weekly nurse-led clinics in the schools, education to staff and pupils in schools, Resiliency workshops in partnership with YouthLine to year 10 students.
 - Member of: [local] Postvention Initiative (interagency group established as a result of high numbers of young people who died from suicide or traumatic incidents), CCDHB Child Youth advisory group, Wellington Hutt Valley Youth Mortality Review Group.
 - Provided at [our venue]: Schools Out (Queer youth support group from Wellington) meets weekly; Careers NZ available fortnightly.

- Pathways, Buddies and a wide range of community houses: Te Mata Hou, Essenic Fellowship etc, etc.
- Peer support programmes are an area that could be of value to primary care, especially in mental health – some PHOs know and support these initiatives and others do not. These programmes could be of benefit to people experiencing mental health problems as they encourage mutual benefit and promote self care.
- Pharmacies. (2)
- Pharmacies and physiotherapist. These relationships are a result of relationship building at an individual level and not necessarily organisational.
- Pharmacies to either get medication blister packed or to discuss other issues. Physiotherapists to find out what programmes are being provided.
- Pharmacies, nutritionists.
- Pharmacies, physiotherapists, ear nose throat specialist.
- Pharmacies/nutritionists/dietitians/sports physios/specialists – we have initiated discussions with such providers to discuss ways to better manage client needs. This benefits all parties.
- Pharmacists, dietitians, massage therapists.
- Pharmacists, drug reps, hospital staff and services in secondary care. Nurse Practitioner and clinical nurse specialists, podiatrists.
- Pharmacists, schools.
- Pharmacy, Colleges, Rongoa Therapist, Massage Therapist.
- Pharmacy – dispenses all medications. Hospice – provides support and (some) intervention for residents under their care. Hospital departments – e.g. acute areas, allied health, specialist nurses – multi-disciplinary approach, meeting varied needs of the residents and promoting seamless care where possible. Local polytechnic (nursing department – PG and undergrad) – supporting practice development of nursing staff, thus improving overall care of residents.
- Pharmacy, physio, dentist, Asthma Society, MOE, NZ Heart Foundation, Whirinaki/ mental health services, CYFS – help us provide holistic service to our target market.
- Pharmacy, physio, Rongo.
- Pharmacy, recreation centre, dentist, advocacy services (e.g. cancer).
- Pharmacy, physio in same block of buildings, good relationships.
- Physiotherapists – various = seamless rehab services. Residential support providers = collaboration on meeting client goals. Commercial businesses = provide employment experience and placement. Government agencies – WINZ, ACC = funding and support for goal achievement. Mental health services = collaboration on meeting client goals. Dress for success = presentation. WinTec = collaboration on meeting client goals (computer). Stewart Centre = collaboration on meeting client goals.
- Physiotherapists attend our breathing groups and are paid by us.
- Physiotherapists, DHB, Dunedin Hospital, Clutha Health First, social workers, Mental Health, occupational therapist, home help providers – all these and many other agencies/organisations assist with the holistic approach to client care.

- Physiotherapy, massage therapy.
- Podiatrists work closely with pharmacists and physiotherapists. There is a podiatry contract with ACC, which is reviewed periodically.
- Private physio practices, therapeutic massage clinicians, providers of equipment, physiotherapy society. Increasing my knowledge of conditions, current research, making appropriate recommendations/advice.
- Public Health Nurses. CYFS Family Violence co-ordinator. Pregnancy help services, counsellors, mental health services – all these improve patient access to available services.
- Public health nurses, Regional public health, DHB, pharmacy, physios, podiatry, midwives. All to improve access for our patients.
- Regional Public Health. Pacific Mental Health – Community Services Pacific Mental Health – Residential Health Pacific Health Services – Wellington (JV for Pacific Smoking Cessation programme) – Pacific Health Hutt Valley (we have started a Doctors’ satellite clinic with this service to provide easier access to clients living in the Hutt Valley). Chemist – supports our clients in ensuring they pick up their medications. Heart Foundation – provides education sessions including staff gaining Nutrition Certificates through their programmes. Breast Screening Services – now housed within our Community Service building – means referrals can be made from GP to educate new parents on breastfeeding. Churches – where health/social promotional activities can be delivered to groups through working together with Ministers. Pacific communities and youth groups – provide feedback to service with regards to prevention and healthy living activities in order to streamline service delivery. Ministry of Health – guidelines and funding. Ministry of Social Development – funding towards Strong Pasifika Family co-ordination. Fanau Centre – Partner within our Collective that provides services to Pacific and others. Maraeroa Marae – Partner with our Collective – provides clinical and community services – primarily to Māori people. Māori Women’s Refuge – Partner within the Collective. Porirua City Council. Whitireia Polytechnic – we provide placements for Pacific Nursing Students. Otago University – we provide placements for 5th year medical students.
- Regular interaction with local pharmacy (sole). Regular referrals to massage therapists, occasional referrals to physiotherapists. Some DHB services have restricted their intake to GP referrals only, which disadvantages our population group, while others have remained open but tightened their criteria within the last three years.
- Relationships with CYFs, Community Mental Health, social services, health services, iwi provider services, early childhood services and others. Staff have some relationships with GP practices, i.e. Practice Nurses usually, as well as staff in secondary services – especially in smaller centres, e.g. they can often find babies/children who are within mobile families particularly in more rural areas. Relationships with Public Health providers where we can support health promotion initiatives as part of our core work, e.g. smokefree, immunisation, accident prevention initiatives.
- Relationships within NGO group facilitate access to services for consumers. Any inter-agency issues are easily addressed and remedied. Collaborative approach to working with DHB. Similarly good relationship with HNZ (particularly Community Housing) and WINZ (Benefits).

- Rotorua District Council, Grey Power, podiatry, nutritionist, Green Prescription, St. John, Residential Care, Police, lawyers, Hearing, Optometrists, Health Gyms, Budget Advisors, Citizens Advice.
- Secondary services, GPs, psychology services.
- Send referrals to physio/occupational therapists and speech therapists.
- Sometimes doctors have suggested to their patients that they attend [our service].
- Speech therapy, Occupational Therapy, physiotherapy, Disability Resource Centre, equipment providers, dietitian.
- Sport Waikato – providing up-to-date information and parent courses. Family Start – working with high needs, high dependency clients in crisis situations. Waikato DHB – collaboration with breastfeeding supports for parent/lactation consultants, adjustment to motherhood groups, oral health advisory group.
- Support workers for NGOs such as Parkinson’s, MND, stroke organisations.
- The Field Worker regularly liaises with and completes referrals to allied health services.
- There are forty organisational members to our Coalition, including the Pharmacy Guild and Physiotherapy NZ, NZ Dental Association, Diabetes NZ, etc. We encourage their advocacy for tobacco control with any and all local and national leaders and their organisations, from the NZ Fire Service, Department of Corrections, as well as their national workforce populations and networks of individual members.
- Waikato Institute of Leisure and Sport. Sport Waikato. Diabetes Retinal Screening. District Nurses. Salvation Army Home Care Services.
- We are a GP practice, therefore have contact with many allied providers.
- We are a resource centre for women, so we have lots of brochures and information sheets on local services, which include many allied health providers, as well as medical practices. These are not close relationships, but we are a centre for information, which helps women reach services that they don't yet know about.
- We are active in an advisory capacity with local NASC services and have established links into local government, disability groups, as well as Pacific community groups.
- We are an adjunct to primary care and we are more likely to refer to a GP as we focus on mental health and counselling and STI testing.
- We are an information distribution point and are very active in the community. We will advise people of what is available to do with a subject/question that they are enquiring about. We have good links to the hospital, regional and district councils and the community groups in our area – 50 of which are affiliated with us. We are aware of the services and facilities in our region and refer people on so that they are connected to their needs in the community.
- We are currently working on promoting the ‘Know your numbers’ heart health awareness programme to a number of organisations, including local govt and workplaces. The purpose of this is to raise awareness of heart health issues amongst employees via an online self-assessment, with the hopeful outcome of people self referring to GPs if they have a concern about their own health.
- We are members on our Smokefree Group which, along with Māori health providers and other NGOs, offer smoking cessation support and run local promotions around being

smokefree. We are members of the Health Promoting Schools group which, along with Public Health and other groups, we support healthy projects in schools. We are supported by a number of pharmacies to help provide clinics and health support to our clients. Our local DHB supports one of our courses by allowing us to utilise the services of a physiotherapist.

- We are part of Waitakere Collaborative Group, where we try to link clients into other services firstly within the group, if we don't offer the service. We try to share information regularly.
- We contract a massage therapist to provide body therapy alongside our multidiscipline therapeutic team.
- We deal with health and social services NGOs and government and it seems to me that one of the benefits is that the other providers really want to know what is happening in health so they are informed, so they can help their clients more with getting well options. So the main benefit I believe is that the client gets a holistic all-encompassing, get-well path with a lot of options and opportunities over many services.
- We do have relationships with the audiologists in the area. In particular Hearing Consultants – Jan Morris.
- We do not work in PH care. We do have some relationships with PHOs and work with them in relation to primary mental health on occasion.
- We do work with independent physios, OTs, etc. We also work with major rehabilitation providers such as Laura Fergusson Trust.
- We don't work in primary care. We get referrals with social services at hospital. We get referrals from WINZ. We have met with WINZ re support available to women and the Enterprise Allowance.
- We get health providers such as physios, OTs, massage therapists to talk to our support group meetings. These let them know what services are available to help them get back to a better quality of health.
- We have a lot of contact with some of these health providers, e.g. osteopaths. We refer clients to one another and have them along to speak at our meetings.
- We have a relationship with a local pharmacist.
- We have a strong relationship with the Health and Disability Advocacy Service. We have a working relationship with pharmacies to establish the best deal for people in our service.
- We have a variety of relationships with other NGOs, such as Diabetes NZ and the societies and kidney patient support groups. As many of our health messages and education are similar, it is often worthwhile and more cost-effective to collaborate on some projects, such as combined screening and information forums.
- We have a very good relationship with our local pharmacy. Our dietitian comes from another PHO, she provides an excellent service.
- We have built strong relationships with our local DHB community team. We would like to further explore developing relationships as outlined above.
- We have contact with a wide range of organisations and networks including pharmaceutical companies, pharmacies, DHB Community Child Health teams (public health nurses), RNZ Plunket Soc, Australasian Society of Clinical Immunology & Allergy,

Ministry of Education, NZQA, ACC, schools, early childhood providers, manufacturers, food industry and regulators, e.g. FSANZ, NZFSA etc. Our overall objective is to enhance health and well-being of people living with allergies.

- We have engaged three qualified physiotherapists to run our regular physiotherapy and hydrotherapy classes for stroke survivors in the Wellington area. We have also worked in collaboration with our Field Officer who is also a part-time nurse at Wellington Regional Hospital to make hospital visits and home phone or personal home visits to stroke survivors/carers/family members where appropriate. Meetings were also set up with the social worker dealing with stroke patients to provide a well-informed overview of issues that stroke patients and their families are faced with following an acute stroke. We have regular contact with the Senior Stroke nurse and Clinical Stroke Physician at Wellington Regional Hospital and run a joint educational day twice a year at the hospital, specifically to educate staff and the public in stroke prevention – and to help reduce the incidence of stroke and serious disability following stroke – through diet, exercise, reduced alcohol consumption and cessation of smoking.
- We have established a relationship with a frozen meals manufacturer who has developed meals suitable for older people. Providing this service has given older people more choice and has also raised the profile of our organisation and the services we provide within our region. We have recently developed a relationship with a local pharmacy chain and as a result, they are now offering home deliveries at no charge to many of our members. We are currently working with MSD to look at establishing a Senior Centre where the needs of older people 65+ can be addressed at a single point of contact.
- We have great relationships with some pharmacies and government agencies. Counselling services have been very useful, especially in Christchurch as there has been high demand for these services. It would be useful to not have such long waiting lists for anxiety counselling services.
- We have invited pharmacists, nutritionists, and dietitians to speak at our public meetings. They are able to pass on their expertise and people have an opportunity to ask questions in an informal setting.
- We have key individuals, including doctors and nurses, who we can contact for assistance for our clients, including special/complex needs they may have, e.g. assisting them to access services or resources available at the Collective. We collaborate with natural health therapists to provide our clients with access to low cost services, including on-site practitioners who come in, e.g. osteopath, naturopath who provides massage (we make the appointments and provide a practitioner room).
- We have ongoing relationships with physiotherapists, speech therapists, occupational therapists, nurses, social workers, government departments, local government, rest homes, commercial businesses. All these relationships work to the benefit of both clients and staff – solidifying the work that is undertaken. Key relationships are important for getting the best results for our clients and the sector as a whole. Often who you know provides significant leverage in terms of getting results and/or addressing serious client needs promptly.
- We have positive but informal relationships with community agencies like pharmacies and alternative health providers.

- We have relationships with all those working with children and youth – some more than others.
- We have a relationship with Asthma Auckland.
- We have relationships with allied health providers: Pharmacist – discuss medicines, their distribution and disposal. Occupational therapist – by appointment through our GP centre. Psychologist – by appointment through our GP centre. Psychiatrist – by appointment through Community Mental Health. Podiatrist – by appointment through our GP centre. Community Mental Health – via an MOU. Voyagers CAMH – via an MOU. Probation – via an MOU. Tawharau Mental Health Collective – via an MOU. All collaborations provide therapy or treatments that we may not offer ourselves.
- We have relationships with CYFS, Family Works, NGOs that have a mental health or drug and alcohol-related contract. Salvation Army.
- We have relationships with other community groups on the island to ensure all community needs are met and no-one doubles-up on services provided.
- We have relationships with Whitireia Polytech to provide the training service/ qualification, and a private training provider. WINZ and Housing New Zealand and Wellington City Council (housing) provide benefits, houses for us to use and move on housing for our service users. We have volunteer counsellors who are in training, providing counselling from our organisation, so we have a relationship with them as individuals and their training courses/organisations.
- We have relationships with ISIS (in Dunedin), GPs, specialists, OTs, physios, ACC, CYF, Workbridge, WINZ, ICC Total Mobility, Alzheimer's, Epilepsy, DRC, Parent to Parent, Stroke Club, Access Home Help, Accessibility Assessment Service, social workers at DHB, Family Works, Health Care NZ, Salvation Army, schools, Police, St John, BUPA. The above organisations are some that we work alongside to provide the best available care for our clients.
- We have relationships with all of the above. Key relationships also with HBDHB and ACC.
- We have sponsorships and supporter relationships with commercial businesses that align with our philosophy and wish to support health education in schools through our agency.
- [We] have strong relationships with health professionals such as speech language therapists, occupational therapists, physiotherapists, dietitians, psychologists as required to meet the needs of our clients.
- We interface with social service agencies in the community to refer our clients on to them for appropriate support.
- We look after a specific group of individuals, some of whom are already in the mainstream AOD Services or Mental Health Services. I think these relationships are paramount in that we are able to assist people within a minority and sometimes stigmatised group, who may have no contact in any shape or form with any medical or health care whatsoever, so these other relationships are very valuable. There is huge value for anyone involved in all help services to learn to network with all NGOs and PHOs in all areas as this can only benefit the consumers.
- We meet with cancer Ministry staff to discuss issues impacting on care and treatment for people diagnosed with breast cancer. These issues include workforce shortages,

collection of breast cancer data and statistics, consumer representation on governance boards, psychosocial issues and so on.

- We occasionally have demonstrations from hospital dietitians and information about medications from pharmacists. Always have backup information from the N.H.F.
- We offer personal experience into such things as osteopathy, anthroposophical medicine, herbalists, homeopaths.
- We own a part share in a pharmacy and wholly-own a significant GP practice. Our sister trust owns two large health buildings and is in the process of building a large IFHC.
- We promote resources and professional development to a range of organisations and professions. We try to work with other agencies on health promotion initiatives (particularly focusing on environment and social change rather than individual).
- We provide education to pharmacy students and refer clients as appropriate to physiotherapists.
- We provide individual, group and family work, as well as promoting awareness of the role of informal carers in maintaining people in their own homes. In the course of providing these services, we have contact with most health and social services.
- We provide information and education to pharmacies, physios, rest homes, midwives, public health nurses and fitness professionals who deal with incontinent people in the community.
- [We] receive referrals from virtually any organisation that works with children and their parents. We provide a process whereby we pull together the various agencies in order to make a specific Action Plan based on the parent(s)/caregiver(s) goals and the collaborative ideas of the agencies involved in the process.
- We recommend to our attendees, people like osteopaths and cranial sacryl people, as well as mentioned Well Care child providers. We have been affiliated somewhat indirectly with Family Start, SuperGrans, Nutra Pharm.
- We refer people to primary health care services – Family Planning clinics, women-friendly GP practices, the services provided by women’s centres, etc.
- We refer to many organisations and these benefit our clients.
- We use and are aware of most of the services in our communities where we offer the programme. We use all the services involved with the older person and access these according to the social and health needs of the service user.
- We work closely on a strategic level with one of the leading rest home providers. We are also working with a training provider to increase the skill level of the workforce in the area of dementia care.
- We work closely with a variety of other primary health providers. Most of the people we support are on many medications, so we have contracts in place with pharmacy groups in Auckland and Hamilton. As funding allows, people have access to other allied health services, such as music and massage therapy and physiotherapy. Funding for allied health services is not covered by the support funding we receive from the Ministry of Health, so individuals and families purchase these services on a case-by-case basis. As this population is generally ‘overlooked’ by the health service, they often miss out on services the general population take for granted. We are also involved in a combined project with Counties Manukau District Health Board to establish a collaborative approach to improve

health outcomes for people with a disability who are ageing or have chronic health conditions.

- We work closely with all allied health providers – within the hospital system, community and private practice – as part of the rehabilitation pathway of our clients. We provide information posters, carry out promotions with pharmacies, refer to nutritionists where appropriate. We attempt to provide a seamless service to the whole community within our budget and resource constraints. We also assist researchers within the public sector and education sector – giving access to clients with their permission or sharing examples of the social stories we have collected in our role working with families/whānau.
- We work closely with pharmacies and in many areas these relationships have been easier to establish than with PHOs/GPs. Mutual roles are recognised and valued. Link widely with physiotherapists locally and through their national organisation; other primary health professionals, such as massage therapists; dietitians on more ad hoc basis. Because we work in management of a chronic condition, this takes a team approach – the more connected the members of the team are, the better supported is the client – similar messages and the valuing of all team roles.
- We work closely with the DHBs, District Nursing and home-based support providers, Streamliners health pathways, Canterbury Clinical networks, NASCs etc. Our relationships and collaboration all has one focus in mind: To assist referrers, providers and all users of the health systems in our region to navigate quickly and efficiently from one service or health professional to another to ensure timely, appropriate services are put in place for clients.
- We work closely with the Kaupapa Māori mental health and addiction organisation, which also provides miri miri and rongoa services.
- We work with ACC and MSD on providing vocational and family support for people with spinal impairment.
- We work with massage therapists who provide low cost massage at the same location as we provide an outreach nurse and GP clinic. We have a relationship with the College of Acupuncture and we can refer patients there for six free sessions. We provide clinic space for dietitian students and the community dietitian who is funded through the PHO. The social worker and community health worker have relationships with WINZ and other local social support services, e.g. Wellington City Mission, St Vincent de Paul, Hope Centre. Midwives have relationship with Pregnancy Help etc...
- We work with occupational therapists in rest homes, hospices and hospitals.
- We work with our families and assess the issues facing them, and work with them for solutions – often this is hospital social workers, midwives, cardiologists, social services, schools, counsellors, etc.
- WINZ, Diabetes NZ, DHB dietitian and diabetes specialists, Hospice, Public Trust, Care co-ordination, community support services (providing home care), pharmacy – all these organisations either assist to meet the clients' needs or provide advice or guidance. Some clients are referred on to them.
- Within [our organisation, our] Aged Care relates closely with Christchurch City Mission and the Family and Community Division of Anglican Care. There is a small but growing collaboration with Anglican parishes within Christchurch, with a view to assisting with

establishment of community services for older people. Regular referrals to Nurse Maude for palliative care and wound care advice.

- Work and Income sites accessing women overdue for screening on site. Shopping malls and supermarkets. Marae-based clinics. Kohanga Reo based clinics. Pacific churches. Community Centres. Women's Centres.
- Work collaboratively with a local mental health advocacy provider.
- Work with physiotherapist, pharmacies.
- Yes – pharmacies and occupational health service, plus dietitian.
- YMCA – [we] pay for a Fitness Instructor to take weekly exercises for our stroke clients. [Our] Community Co-ordinator liaises with Turanga Health [and] makes regular visits up the East Coast as far as Ruatoria. Regular networking by our Community Co-ordinator is maintained with the City Council, hospital administration and other disability groups.
- Yoga, Kapiti Mental Health, Kapiti Youth Centre, Police, Housing, NZ Community Connections, Pharmacists, Kites, Mary's Guest House, Work and Income, Buddies, Te Nikau Addiction Centre, Kenepuru Hospital, Foodbank.
Benefits: Our members benefit when we link in with other services around things that they struggle to manage due to their unwellness, i.e. depression, anxiety, post traumatic stress etc. This linking enables our members to manage their everyday living in a much smoother way and a pathway to becoming and managing their mental wellness.
- Youthline/CMDHB – drug counselling service for students. Whirinaki – adolescent mental health. Mighty Mouth – dental care.

Comments from government bodies (e.g. DHB public health staff, MSD, etc)

- Breathe easy support groups across our region – initiated by our service and function independently – also linked with PHO-based chronic care nurses. Supported the professional development (to proficient level) of PHO and iwi-based nurses utilising the National Respiratory Nursing Knowledge and Skills Framework. Work alongside iwi and PHO-based nurses in outreach clinics – collaboratively – clinically and culturally synergistic.
- Career Services, youth services (e.g. Evolve, Challenge 2000, Incredible Years Trust).
- Close relationships with pharmacies – medication dispensing, monitoring.
- Community pharmacies, laboratories, radiology and other diagnostic facilities, as well as allied health such as podiatrist, nutritionists, social workers, etc.
- Field officers for specific illnesses, such as Parkinson's disease. By working collaboratively, we can improve our client's journey.
- Hapai te hauora tapui – Public health – Like minds.
- Have a good relationship with the community pharmacy; with an outlet in the township, the community has good access to those needs.
- I believe it is critical to work together and to prioritise these relationships.
- I establish/maintain relationships with any allied health provider required to provide funded access to a variety of health and disability needs for clients.

- I have an excellent relationship with all our local pharmacies and give them lectures on the latest diabetes devices and newer types of insulin. Phone contact is regular and I will see clients at pharmacies if there is privacy. I leave them a stock of Insulin pens should a client need a replacement, as some clients live three hours from our offices. I have liaison with all of the hospitals/rest homes in our area and give lectures/advice by phone, and visit if needed. The nutritionist (who is employed by Whaiora Whanui), is greatly involved with our patient self-management sessions for people with diabetes. I work with CYPS when a child with diabetes/asthma is involved with their service. I speak to pre-schools and kindys re diabetes/asthma management for children in their care. Diabetes patients often require referral to podiatrists who are very much a part of the diabetes service. Podiatrists also give advice on footwear, foot products and treatments.
- Pharmacies, nutritionists, Work and Income, employment agency.
- Physio, forensic services, CATT team, A&D providers.
- Regularly refer children to Audiologist, Physiotherapist, Occupational Therapist, Child and Adolescent Mental Health. Advise families to pharmacist in the community for information re medications and OTC products. Suggest those seeking alternative health therapies to Homeopathy therapist. Advocate for children when they are involved with CYFS. Advocate for families when they are involved with WINZ or Housing NZ.
- Relationships with the national organisations representing most primary health care services – both medical and others. Work with Ministry of Health, Corrections, Housing. Work with DHBs.
- Strengthening Families, pharmacies, community physio.
- TLAs, sport and recreation organisations.
- We have good relationships with all pharmacies in the area and they all know us. We have good relationships with churches and local Pacific providers. We work closely with CYFS and schools and courts, family court and some lawyers. We sometimes ask nutritionists to come and talk to us about their role and how we can help the Pacific community and our clients to eat healthy.
- We have good relationships with our pharmacies around whether clients have picked up their scripts etc. Pharmacies will often deliver to our clients, which is very helpful. We even have some pharmacies who we work with regularly, who will occasionally dispense for free if the client is unable to afford the cost.
- We have relationships with: DHB Child and Family or Woman and Family services, Plunket, Public Health Nurses, Child and Adult Mental Health Services, mental health NGOs (e.g. Connect Supporting Recovery, Walsh Trust, Affinity, Equip), disability services (e.g. Taikura Trust, CCS Disability Action, disability NGOs and respite providers), some Māori health PHOs and NGOs (e.g. Waipareira Trust, Te Puna Hauora, Te Korowai Aroha), Work and Income, Child Youth and Family. These relationships benefit our client families as they know about our service and refer the families to us. They also support their staff to attend [our] meetings for the families they are working with. At the meetings they too share relevant information about the family's situation and the services they can provide, which helps all agencies and the family to build a successful action plan for assisting the family. The relationships with Work and Income and Child Youth and Family assist with finances for some plans and services.

- We have strong links with allied health professionals throughout the DHB and ACC sector throughout New Zealand. We have strong links with disability support services providers throughout New Zealand. We have service relationships with information services providers for disabled and older people throughout New Zealand. We have strong links with home-based support and residential care providers through the MDHB region. All these relationships are essential for us to deliver the services we deliver in an effective and responsive manner.
- WINZ – assisting clients with benefit entitlements. Accommodation agencies – sourcing appropriate accommodation for clients on discharge from our service. Banks – assisting clients to access money and track their transactions.
- Work and Income based a person in our centre once a week.

Comments from commercial providers (e.g. private practice, specialists, etc)

- Aged care, pharmacy, OT, physio, dietitian, gyms, Heart Foundation, Stroke society, etc.
- As mentioned above, contact with other health providers occurs when they have a need to discuss sleep issues, or have clients who need help in this respect. I also refer my clients to other relevant health providers, including nutritionists, psychologists, and other medical specialists.
- Assess and refer employees following accident or injury for employers that manage their recovery programme outside ACC.
- Chiropractors, osteopaths – benefit client in terms of structural adjustment if needed. The primary care I offer already encompasses Naturopathy, herbal medicine, homeopathy, nutritionist and massage.
- Co-located pharmacies, physios and dental units. One-stop-shop scenario.
- Hospital diabetes clinic.
- Our most recent collaborative work has been with the Ministry of Education who supported our validation process of an Adult and Youth communication tool utilising public health and school nurses.
- Pharmacies, physios, dietitians, exercise, osteopaths.
- Pharmacy.
- Pharmacy, physio, OT, GP, specialist health providers, ACC.
- Podiatrists for people with diabetes. Well-elder services for people 55 yrs of age + offer minimal/free counselling services. Laboratory services for all people including their staff needing Hep B vaccinations. Radiology services, hospice services, retinal screening providers – for people with diabetes. Collegial relationships with other medical centre staff – help each other out. Private hospitals and specialist services.
- Providing access to these agencies via Interpreting service.
- Strong relationship with most pharmacies – enables fluidity in the script/medication process and thus avoiding potential barriers for patients. The fragmented nature of primary health care services makes relationships with other providers difficult – ‘contract’ holders change frequently (well – they certainly are under this so called ‘more effective’ system that is the current fashionable attempt at improving PHC service

What makes a difference?

When asked to identify key triggers and barriers to collaboration, respondents provided the following comments, which include much broader suggestions for change:

- 1. Triggers of poor communication around the history of consumers.
2. Future changes would be knowledge of services provided by other organisations so we are all providing our own intervention strategies for consumers so that we do not overlap on services provided – making it easier for consumers to access services with minimal stress and confusion leading to mental wellness.
- A key lever for us is the benefit we as an organisation – and the four individuals who work here together with a network of consumers – can provide to primary health PHOs and GP practices in strengthening the consumer voice and challenging stigma and discrimination within the health sector. For those of us with lived experience of mental illness – and of recovery – we know that sharing our experiences will help service providers better understand mental illness from a holistic and service user perspective, rather than a clinical/medical/therapeutic perspective.
- A system or referral process that is accessible, and does not have a lengthy wait list. The opportunity to know more about what is out there for my clients. Also the opportunity to keep in contact with others working within the Primary Health Care sector.
- A true commitment by the PHO to funding health promotion and community health screening and education regarding chronic conditions and parenting.
- Active participation of people who experience mental health problems and access primary care working collaboratively in reviewing and planning services. Consumer participation is crucial and is likely to require support to make it happen, as primary care does not always know how to go about this.
- Actually due to changes in funding, some of the PHO-NGO interface has disappeared. We work collaboratively with PHO-NGO to run exercise programmes for patients with COPD and some of the people involved in this have lost their jobs due to reduction in funding. It has been a big challenge to keep these programmes going. Key triggers to developing integrated models have been staff who share the same vision and are willing to work together to meet patient needs. Clarification in contracts would help work out which PHO-NGO to approach. We are very lucky with the PHO in the Porirua region, which is very willing to work with us to provide follow up programmes.
- Agreed expectations and vision. Joint funding initiatives. Increasing interactions and understandings of what each other do/stresses/constraints on services.
- An understanding of what each service offers the consumer and sharing this collectively to help the consumer on the right pathway.
- Answered earlier.
- As a Pacific community mental health support service, we have Pacific models of care that are ethnic specific. These are important with addressing specific ethnic cultural needs of our service-users and their families, for example: the importance of the values around spiritual needs.
- As a PHO, I have found that developing very close relationships with all service providers GPs, Māori health colleagues and an interdisciplinary team approach works well. Meeting

regularly to discuss complex care reduces duplication, ensures effective communication and responsibility for care. I think that local solutions need to be supported.

- As previously noted: Our organisation has lead the vitalisation of Whānau Ora into health services in the region. Our midwives provide care to the most disadvantaged and are leading stakeholders in the vulnerable women’s initiative for the region. We provide leadership in the region’s breast feeding strategy, in collaboration with iwi and providers. [We are] a committee member of the Iwi Te Pae Pae Matua Rongoa initiative and provide clinical director leadership to other Māori health providers and Māori NGOs. Provide leadership to Nga Maia Moair Midwives collective and NZNO Māori caucus.
Future changes: Communication continues to be a barrier and adequate skill and cultural base at all decision-making table/forums. The DHB remains unclear on its strategy to support collaborative and integrative relationships in the primary setting. Unfortunately the strategy remains non-transparent. Until these fundamental issues are resolved, it remains status quo for now.
- Better communications – especially from GPs and their nurses. Openness to other models of care or wellness. Early intervention and communication of that through all the various support networks around that person.
- Better dissemination of information about service providers to members of the public.
- Bright screen tool being rolled out so NGO field staff can use with clients. Shared training. We liaise with GPs when clients have medical issues related to their abuse or neglect case, but rarely are we contacted from their end when they may have a patient with potential abuse or neglect issues or social isolation.
- BSMC [[Better, Sooner, More Convenient](#)] is the catalyst.
- Cancer patients used for guinea pigs with the new drugs – are not cared for and are expected to travel to and from the Middlemore Hospital and their home. They are not fed while at the hospital all day. Northland health gives a few dollars in petrol chits and again our Māori Kaumatua and Kuia are treated like %@&* and the systems continue to sit back and get away with it. If you are serious here about this survey, then do something to enhance our old people’s lives now.
- Can’t say.
- Co-designing with consumers and all involved.
- Commitment on a philosophical level. Openness to innovation by the funder. Strategies to overcome the problem of ‘silos’ in funding
- Commitment to change the way of working within PHO environment. Funding from our organisation to support the work we do made a huge difference in engagement.
- Constant interaction and communication, and sector interest groups meeting together and planning – provision of specific responses to the needs around the earthquake for example. A continuation of collaborative responses arising out of the earthquake would be beneficial to clients/consumers, and keeping the client group informed to enhance their input into collaborative approaches – this would assist in service integration.
- Create flow charts to enhance each operational aspect by all involved with ‘a process’ that will give quick reference to the ‘action’ required. Data collection by those out in the field interface is imperative – that will indicate what is working, at what costs. Getting the client to participate by furnishing simple surveys. Communicating data results at team

debriefing meetings will gauge team building and cohesion to make the difference happen.

- Development of integrated information systems to enable sharing of information regarding shared clients – to enable timely interventions to enable health outcomes.
- Discussion and co-ordinating client care. To change funding basis to reduce duplication and enable services like ours to provide home-based services, instead of when clients are mobile and able to access clinics, but do not want to pay.
- Don't believe anything much has changed over the past two or three years. PHOs didn't actually live up to what was expected of them.
- Early referrals particularly from GPs. Knowledge of our services so that people can refer. Good working relationships with other service so that we all know what part we can play in the person/family journey. We need more funding to be able to provide services in the community. We are limited not by our imagination, drive or ability, but by the financial resource to deliver services.
- Everyone using and accessing one assessment tool, i.e. interRAI.
- Face-to-face contact initially and then building a relationship by providing clinics at Health days and following on from that with monthly clinics as needed. Funding for advertising to make people aware of our service is what we need most.
- Face-to-face meetings are the only thing that works, but also good specialist opinion letters and regular reports back to the GPs. We also are unique in that our staff are part-employed by the DHB-funded specialist service, but also part-employed by the hauora as the primary level of mental health care. Your group would do well to meet with me and/or solicit a paper on how to integrate primary mental health care to those aged 0-17. The current situation is totally random and chaotic. We need a plan that integrates all currently-funded services, develops an infrastructure that would deliver services efficiently and effectively and raise the standard of care given to that approaching the best available, instead of wasting a fortune on good organisation and programmes. Some kids get too much 'care' from too many and most don't get any at all.
- Focused on children. There was common agreement that children's needs were not being met and less 'blame' associated with working with children. Strengthening Families is a great model that we use frequently. Shared notes and e-referrals. Preventative plans and referrals to address the side-effects of anti-psychotic medication. Brief intervention groups for anxiety and depression. WHOLE family/whānau assessment and referral of family/whānau to organisations such as ours. Nearly every family/whānau who is concerned about their family member's mental health attends their GP and informs them or asks them for information. Nearly every GP responds by saying there is nothing they can do without seeing the person and suggests they get the family to 'bring them in', or to wait until it is a crisis when the CAST team can be used. Only one or two individual GPs in greater Wellington will suggest the family gets information and support for themselves or makes a referral to our organisation. As [we] have branches across the country we know that this is a national issue with the exceptions being in smaller rural communities where the GPs know and use the local services in their work.
- Formation of a primary care advisory group encompassing representation from most, if not all, local primary care agencies with a representative on the PHO Board.

- Forums for networking and facilitating relationship development amongst providers. It is important that these are driven by the providers and not the funders. One-stop-shop scenarios whereby the holistic wellness of the client can be catered to on one site, with different groups providing for different aspects of care, according to each group's expertise. More education about PHOs, who they are, what they do – why they exist, how they differ from other groups – is it merely their funding sources that defines their difference to other NGOs?
- Frankly the recession has almost forced groups to work together more and there has been significant benefit in this. The downside, for policy-makers, is that much of the benefits to both the consumer and the bottom line will not really be seen for some time to come. We know our interventions prevent crisis situations and have a positive impact on people's health and well-being – resulting in lower admissions to hospital, emergency departments, residential care facilities. However this can only be measured accurately over time. The better or more accessible our interventions are, the greater the impact on the health service as a whole. The PHO-NGO partnership needs to be encouraged and resources invested to help this happen. Many NGOs are now staffed with professional, competent people who deliver an important service in the community. This work has value, needs to be recognised and supported along with the work done through the PHO. Service NGOs in particular find it difficult to generate funds as (often) over 75% of their expenses are staff-related, so to work with PHOs some investment would be needed, however this may be less than if the PHO provided this service themselves.
- Future changes – funding and working together collaboratively are areas that we struggle to access. A streamlined way to access information about how we can contribute to other primary health care providers' models of care, and support to do this would enhance our ability to work together. We have unique and excellent services running here, but are unsure of how to promote this to local PHOs and tie this into their funding streams and their current priorities. If we had a single liaison person who understood exactly what we could offer and could then help us link into current projects we would be well-placed to contribute more effectively.
- Future changes we would recommend to PHOs are:
 - i) nominate and make accessible a person/contact specifically for NGOs to discuss possible collaboration
 - ii) be willing to work collaboratively, including joint applications for funding, etc
 - iii) acknowledge the value of NGO support for patients, particularly in managing chronic health conditions and make referrals sooner rather than later.
- Future changes: more robust communication from PHO to grass-roots NGOs and vice-versa. We often get people saying "I wish I'd known about your service earlier" despite the fact we distribute brochures throughout our catchment area.
- Future: Working closer with GPs and other allied professionals to return people to work or community roles as soon as possible following illness or injury. Similar to the 'Better at Work' pilots in place with ACC and GPs. Working closer with hospital rehab departments to return patient to pre-injury or pre-illness roles or explore new roles with support. Better use of local providers.
- Have had many discussions about the need to move to incorporate a stronger psychosocial model into primary health care. Particularly for mental health, where social indicators have such a weight on consumer well-being (e.g. access to social workers in

the community, rather than just within the hospital setting). Would like to see funding available from the PHO to have social workers in NGOs or GPs' surgeries... better still both!

- Having desire to work together and making it happen.
- I do not believe that collaboration between NGOs and the DHB is likely to change, however at a nursing level there is considerable motivation to achieve the best possible outcomes for our clients with the available resources. To this end, we will continue to liaise and collaborate at an individual level.
- I have worked in primary health care since 1994 and feel the patient/client gets less care now – we are all too busy with added unnecessary admin to provide a job for someone in a PHO or related industry.
- I mainly deal with palliative care patients – primary and secondary areas work together to integrate patient care.
- I think NGOs have always networked with each other and collaborated, although in terms of joint contracts this is more recent and more noticeable in abuse prevention MSD contracts.
- If providers genuinely have models of service that have the person at the centre. Time and resources to really develop good working relationships between agencies, not just individuals.
- Improved awareness around issues. Less silo thinking, for example, a more integrated approach around addictive behaviour – rather than different A&D, Problem Gambling and other addictions such as smoking cessations work – being more collaborative within these fields, and Mental Health.
- Information sharing across providers. Clearly stated policies that work in line with other agencies. Better understanding on the needs of people with complex physical and intellectual disabilities. Better processes and guidelines for these people also.
- IT Link up. More feedback from GPs on our referrals – too often left to patients to provide the feedback. Involvement in establishment of Integrated Family Health Centre (currently excluded as members of core group).
- It's about education and I am available for that to discuss my role and duties of providers and Rights of Consumers.
- I've been in this field for 22 years. In my experience, the only thing that makes a real difference is when contractual drivers push the issue. The contracts which state that teams have to be made up of members of a variety of disciplines have been the most successful way to bring changes. One thing that pushes fragmentation is the funding process. Organisations, especially NGOs, will often start up in response to getting funding. For example: a charitable trust may have to splinter off to extend their work, and form yet another trust. Funding bodies have no accountability of where they allocate funding. I remember once finding that there were six organisations in our DHB, who had prevention of youth suicide as their main focus. Half of these organisations were unknown to me – which was surprising given that I have been involved in youth health for over two decades. It is really difficult to get inter-agency collaboration among a large number of small organisations. I have suggested that there is an over-arching body, which could put more rationale into funding decisions to drive better collaboration. Alas,

we are a long way off from that ideal, but my own view is that there is a lot, and I mean a LOT of money swishing about, but it is poorly directed and not well-used.

- Knowing what is available to access. Shared plan between the primary care, DHBs, the in-home supports and the others like us who come from the NGOs. Having a consistent 'face' to an organisation really helps with collaboration networks. Also knowing who does what can enhance service delivery and stop any lap-overs of delivery.
I personally feel the assessment area way heavier than what actually gets delivered to the consumer. You can get assessed up to the eyeballs and end up with $\frac{1}{2}$ hr per week home help or nothing, or wait three months for a walker with skis on, but you really needed one with 4 wheels on that [the service] said they could not supply; or 5 assessments later (e.g. GP, CCC, Enliven, Physio, OT) and you end up paying for your own shower handle – builder put the handle on from Bunnings. Four specialist visits and six appointments for a hearing aid after trying ACC way first – process took 18 months – after going to C&C, had a subsidised hearing aid within 6 weeks. At the moment we are working towards completing Health Passports for those service users wishing to have one to take with them to appointments and admissions incl. residential care.
- Less medical-based models of care delivery, a willingness on the part of the PHO to engage with the NGO sector, renting premises to NGO providers at a non-commercial rate.
- Look when are you going to get it???, the pakeha are in it for self gain... not whānau gain.
- More info and training. Cost.
- More realistic funding and outcome measures. NGO funding needs to be equal to non NGOs. Contract parity will allow us to pay parity for staff.
- More referrals to our breathing groups. I take the Greytown one and I found that people attending our group stayed in better health. Mentally and physically as they give each other a lot of support and care about each other. These are people who travel from Carterton, Greytown, Featherston, Martinborough and outlying areas each week to get to our group. Non-attendance is most often due to them travelling or other commitments that day. All of them say that it is the attendance to our group that has kept their health up.
- Most of the questions do not appear to be applicable to us.
- My experience would indicate that if you are not known to a part of their hierarchy, then you do not get recognised. 'They' being a big organisation, should be getting more involved with rural communities – letting them know what they can offer families. However it seems that small communities have to spend significant time trying to find out what is available at a cost to people who already volunteer much of their time.
- My key levers or triggers are initiation of contact and persistence regardless of the response, which can be good or bad in my experience. I involve as many others currently involved in the existing care as I am aware of in preparation for progress. I begin from a position of respect for the professional integrity of the provider in my query, and raise the strength of my argument according to the level of barrier that I identify. I use key strategic plan documents to quote health professional obligations in duty of care if I need to advocate for whānau/client's best integrated care. Being invited to present an overview of my scope of practice to as many professional disciplines as possible, to save on having to do this piece-by-piece, thus cutting down on the time I have for direct

service. Questions and answers would then clarify referral criteria, while providing the personal interface so necessary in building rapport and trust. Urban-based services having an increased awareness of the travel constraints faced by rural practitioners. This impacts on the delivery of services to communities already disadvantaged by losing services due to cutbacks. Visits from urban practitioners are most appreciated. If there is administrative support given to them in the form of panui sent out in a timely manner to a range of agencies, their time could be likewise optimised. A month's notice to the whole network from one source would be preferable to being the last link on a communication tree, which can rule us out from attending altogether.

- No real difference has been made – lots of talk from the new *Better Sooner*, but in actual fact, one medical centre has become so big that the service to clients/patients has become less personal and user-friendly.
- Not really relevant to our organisation.
- Nutrition – when clients are first assessed, it is very apparent that many are not eating a nutritious diet and have a poor hydration level. Lack of safety issues in the homes – rails, shower handles, strollers/frames; bathrooms – unable to get into the bath – more need for financial assistance to modify bathrooms to increase client independence to use a wet area shower independently, instead of using support persons to assist on to bath boards and provide shower support.
- One-stop-shops for really 'at risk' individuals and youth, e.g. Referring on or self-referring does not necessarily mean it will happen. People get lost once they leave you. We need better ways of getting people to specialty services. Sometimes funding prohibits good follow up treatment. Keep on identifying barriers to better health care for all people, all ages, all ethnic groups.
- Ongoing interaction with other providers through education, regular meetings, etc keeps lines of communication open and improves understanding of what other services are available to clients and how to access them.
- [Our] commitment to excellent service delivery is evident in that: [we] participate in national and international research. This provides an opportunity to 'capture the Voice' of our young people, exposes staff to the research process, ensures the service is informed of current evidence-based research and provides some revenue.
- Our observation is that PHOs keep clients within their own systems and GPs don't refer out to community-based experts – even though the service is free to the users and there is absolutely no doubt as to the comprehensive services offered and the quality of expert care and knowledge (confirmed via DHB audits). We train Medical Centre Nurses and we know they don't run clinics and we know they don't offer education to their clients. The clients miss out and end up finding us. Many become very angry that no-one told them of our services earlier, or explained how to best manage their condition earlier.
- Patient/family centric – one size doesn't fit all. This may also help identify family groups that require an increase in services to ensure that following generations are healthier.
- PHOs do not seem to know we exist – education/information.
- Recognising each other's strengths and working together to develop and provide a service to a rural community as a pilot. NGOs typically run on a very limited and stretched budget and are therefore continually looking for ways to continue to provide their services to a growing market. One of the best ways to do this is to work together to keep

costs to a minimum. This also ensures that we are able to share resources where appropriate, share knowledge and widen our client base on the same, less or (if we are lucky) slightly increased budget.

- Recognition and networks.
- Recognition of traditional Māori practices as legitimate means to improve wellness. Whānau Ora has driven a more integrated approach, which is in keeping with a Māori holistic view.
- Referral systems and increased communication. Doctors understanding Parkinsonism diseases.
- Referrals from hospitals after a patient has had heart surgery or other heart treatment, along with local doctors advising patients about the benefits of sharing their problem, while gaining other types of backup support.
- Referrals made to NGOs as soon as diagnosis is made. Organisations such as ours have been set up to provide support and education to people that is not available elsewhere. Having the right information and support helps people cope for longer and helps prevent carer burnout. We can steer people in the right direction to get as much support as possible.
- Regular meetings of professionals to discuss concerns/issues if safety issues identified. Open collaborative relationships with other agencies. Agency desire to improve outcomes for clients collaboratively, instead of just referring on. I often find it is a particular worker in an agency who has a real desire for positive outcomes that makes a difference to the client – workers who will go the extra mile. So I would see it as important for workers to be supported to do a good job and clear systems of accountability in agencies with regular checks in place.
- Remembering to provide a client/family centred service – ‘for whom are we here to serve???’ I see some great opportunities for PHO and NGOs to work together to provide positive outcomes for people with a ‘shared’ cost. PHOs do not appear to be as approachable or creative with their resources as in the past in my opinion.
- Removal of the business structures that separate secondary and primary, and a joint way forward with all professional groups included, where the dominant discourse is client and family access and not a medical model.
- Secure funding for services – to allow true collaboration to occur – not being forced into an open competitive tendering environment.
- See that having a liaison key worker from Community Mental Health working with the PHO medical centres is of great benefit to our family/whānau caregivers and also adds value to the improvement of wellness and early intervention for the service user/consumers.
- Shared values and beliefs and capacity available at same time; shared focus on outcomes that result from shared activity.
- Shared vision for consumer/client, not for organisation.
- Some of our interactions to enable better services for our clients are hampered by the restrictions of the Privacy Act, also some organisations do not recognise our service as part of the process of rehabilitation and only contact us when a crisis arises.

- Some referrals for breastfeeding support, since mother-to-mother support is a key factor in sustaining breastfeeding.
- Sorry, but for the most part I don't yet see significantly more integrated models of care. What I do see are some specific programmes (e.g. Green Prescription, Smoking Cessation) that are funded by the PHO, but our clients are not asking for those and thus not engaging with them. Yes they realise they are overweight and that smoking is not good for them, but they are too overwhelmed by other life crises (e.g. family violence, other relationship breakdowns, extreme financial stress, urgent housing needs, addictions) to have the energy to get on board with healthier diet and exercise. One of the most effective collaborations however, was several years ago between the local DHB and the Nelson Tasman Housing Trust called 'Healthier Homes'. This project retro-fitted 450 older (pre 1977) homes with insulation and draft-stopping. The results included dramatic improvements in residents' health as they got sick less often, and chronic conditions such as asthma and allergies improved because they were living in warmer, drier homes. Visits to GPs, A & E, and hospital admissions markedly declined. Funding for this has now stopped, although Nelson City Council (and central government) have since set up similar initiatives to improve home insulation via subsidies. Unfortunately, most poor people live in rental housing and the uptake on these schemes by landlords has been relatively low. Owner-occupiers seem to have gained the most benefit from these insulation schemes.
- Start looking outside the box at other models that are working well in other countries. Such as [Trieste Model](#) and [The Living Room Model](#).
- Suggested Improvement: Ability to provide personal and home care services to residents of our retirement villages ourselves, rather than have another contracted provider visit for maybe 30 minutes/day and our staff remain responsible for oversight and emergency care the rest of the time. This is disjointed and leads to a lack of information between the organisations.
- The [BSMC approach](#) to health care delivery making services close to homes of people and integrating services around people. We have developed the only shared health care record in New Zealand, which the patient can also access.
- The difference will be made if there are efforts to understand different cultures. For our service, we called a fono (hui) in 2006 and said "These are the services that we deliver. We are not a GP but we provide community health and social services." The feedback was overwhelming. Many Pacific people were not able to access GP services in the area because the books were closed, they didn't understand what doctors were telling them, they didn't understand their medication so they never picked up their meds, transport was a big barrier as well so they didn't go to their appointments. They wanted a Pacific GP. A business plan was completed, funding acquired, Pacific doctor acquired, and the first 'Pacific built for purpose' GP was launched by Hon Bill English in Cannons Creek Porirua. Currently, we are developing a model of care with our PHO based on the information we have given. This works and is supported because it's the feedback from communities that has enabled us to achieve a number of things, including Healthy Lifestyle Pasifika Programmes.
- The doctors should have the charge of being a doctor. From what I have seen the changes are not being felt in the community, we have people come to ask us what is a PHO and who are the PHOs. There have been in the community, very effective NGO

groups for years that have operated on a volunteer basis and very little funding. Diabetes, Epilepsy, Heart, Cancer, MS, Parkinson's, etc, etc. They all have an educational aspect to them. These organisations are often over 30 years in existence and are well known. The PHOs are ending up duplicating much of what has been done already and is in existence already. They should utilise that which exists and support them and if those groups received the funding that the PHOs are getting, then we may have some real community impact, as it is people in the community helping people in the community.

- The fact that the health professionals are showing a concern about STROKE is going a long way in providing the best possible care for stroke survivors. This is shown by making prompt referrals, access to stroke survivors and their carers. Liaison with health professionals, including social workers, is essential for the well-being and rehabilitation of stroke survivors. Stroke has been given a higher profile in recent years. We have benefitted from visits by researchers from the Neurological Foundation of NZ. It is our hope that all medical professionals will receive more education about stroke. This is beginning to occur.
- The GAIHN programme was a great start, but it does not seem to be getting support from the DHBs.
- The health system is complicated and getting more complicated all the time. Different funding streams, repositories of information, services, criteria etc, etc. It is impossible for health professionals to be aware or have up-to-date knowledge of all of these factors. If it were an expectation, it would use up huge amounts of time that should be spent on patient care. I believe an organisation such as ours with the ability to provide one point of entry for referrals, assessment and co-ordination of services is becoming more and more important. The operating system and data warehouse would provide one source of information about community services and data and reporting to support decision-making. A streamlined, joined-up consistent approach across primary care to the benefit of health professionals and clients.
- The implementation of a formal Advance Care Planning process, although in the early stages, has significantly improved outcomes for residents, and involved GPs without increasing the burden of their workload. It means that residents have the opportunity to have conversations about their care and treatment, and medical situation, and express their wishes, values and beliefs so that when healthcare decisions need to be made, the decision-making process has already begun, often avoiding crises, and easing the burden for GPs – and ultimately the resident is more likely to receive care and treatment that is in line with their wishes. So far the Nurse Practitioner has been the person to have these conversations, but a training programme for other experienced nurses will be implemented. This is something that would benefit from being implemented across the wider primary care sector. Advanced nursing roles truly add value to healthcare delivery, and improve intervention and outcomes for people. Nurses in advanced roles have the ability to work in a collaborative way, with good communication and integration skills, helping to provide seamless care. They also have leadership and change process skills, and are able to lead effective quality improvement and change processes across settings and disciplines (particularly NPs), thus facilitating proactive intervention and service delivery. I feel much more support and funding needs to be given to the development of advanced nursing roles across all primary care settings. As we know, population needs are changing and the current (largely) medical model of service delivery is not going to

keep up with the increasing needs – we need to make better use of our GPs, and develop innovative ways of supporting the services they provide.

- The key to improvement of primary health care and better integrated, collaborative support services for stroke patients/clients in Wellington hospital and the community is personal communication and effective two-way education provided by individuals working at the 'chalk face' with their shared consumers. As a stroke survivor, [a] Stroke Club Co-ordinator and a volunteer in Wellington Regional Hospital in Levels 5 and 7 South, plus the Emergency Department, I first approached the Senior Stroke Nurse to speak at our Stroke Club and later she approached me to help with a Stroke Prevention Education Day at the hospital. Now both events are annual events. I suggest that future changes should include: Continued, regular and effective, informative two-way personal communication, and exchanges between the primary health providers and members of the voluntary organisations in the community – workers at the 'chalk face' – with their shared clients – to truly add value to improve wellness and early intervention and more effectively integrate services across the primary care/community interface.
- The people working in these organisations are often the key – most of the effective collaborative work I have achieved in the community has been because of the enthusiasm and commitment of a handful of key people wanting to make things happen. A commitment to principles of community development can be an effective lever. An awareness of the importance and value of health promotion principles and a commitment to the treaty and reducing inequalities.
- The real difference was the amalgamation and a commitment to focus on, for example, Māori health outcomes as part of continuing care, rather than the one-off clinic that used to be funded. The other driver was a commitment from the PHO to be a purchaser rather than a provider.
- There has been more interaction with the DHB over contracts etc and I think this has helped improve services for the clients and the services – this interaction has created a more integrated model of care. The shift from the PHO to Midlands Health Network has been difficult, with very little interaction from Midlands and I feel they are not sticking to their business case presented and not interacting with services. Would like to see the GPs more open to collaboration of services. Sharing information when requested etc. There has been more interaction with counselling services, which has been great and having a counsellor provided onsite, which we had to battle for, has improved services to our young people.
- To get rid of the medical model of care and business model of GP care – pay all GPs the same salary. Many GPs are not prepared to work together. Their work is financially driven. I suggest that the playing field be levelled so that all patient charges are the same and GPs are paid the same, and then maybe the integrated family centres could be created with a patient focus, instead of a business and competition focus. Many GPs are not accountants or necessarily good managers. They are charged with this responsibility within general practice and the practice revolves around them and their needs, instead of the whole needs of the community. Many GPs do not look after their nurses – they under pay and do not support their nurses' education needs. Many do not understand that nurses practice under a Health Competency Practitioners' Act, and many nurses are asked to do things outside of their scope of practice by GPs. Many GPs are out-of-date with their practice – locums especially – and give direction for unsafe practice, such as

administration of IV fluids overnight in the home with no direct supervision/pump or follow up, and no responsibility is taken for this if something goes wrong. Many GPs are lazy and leave it up to nurses to provide care at home for the dying and do not support families well – do not hand over to other GPs the duty of care when they are off duty. Development of nurse-led clinics is paramount. Nurses are the way of the future for primary health, they are a professional body with a good national infrastructure, which advocates for professionalism and accountability with strong motivation to improve mechanisms for education, research and policy and communication networks. Nurse practitioners should be encouraged to take lead roles in improving wellness and early intervention screening within Integrated Primary Health Care. District Nurses should work closely with GP practices to be the intermediary link between primary and secondary health care – they are excellent generalist specialists and are well-resourced with strong links to all services. We had an excellent Diabetes Co-ordinator here who has had the funding pulled (PHO) and now all this work will be devolved back to the PNs who are already overworked, underpaid and under-resourced. There will be no direct link to the diabetes service – seems crazy that all this good work in developing links and support structures will be undone.

- To make use of the clinical expertise of clinicians working in the field, value their input regards delivery of services.
- Tobacco Control Update research section and editorial, website pages reflecting the Vision for 2020, PHA Conference presentation, Tobacco Free Aotearoa Conference, Health Promotion Forum symposium and whānau ora workshops. Consistent attendance to and advocacy for more consistent attendance and involvement from members' regional offices in the regional smokefree networks. Revisiting the terms of reference of the national tobacco control working group, to focus upon its best practice representational membership for the regions, streams of information from the regions turning into next steps/prioritisation in policy-making/advocacy at that meeting table, that in turn flow out nationally through those strategic representatives.
- Triggers: Evidence-based annual health assessments to improve health outcomes for people with disabilities, working with the GP and practice nurse for a more integrated approach.
Changes: GPs to be open to other ways of health care for people with disabilities. Some people with disabilities require a different approach, so investigation and treatment flexibility is essential. Establishing an IT platform for ease of sharing medical information between District Health Boards, PHOs and disability providers. Financial support for people with disabilities, on very limited income, for annual health assessments. Pro-active health care will save a large amount of health budget, which would be spent on the cost of numerous reactive admissions, specialist visits and GP time.
- Using a mental health promotion perspective. Being involved in Like Minds projects. Regional areas seem best – everyone relies on each other. Otherwise, single topic education sessions for staff.
- Waikato DHB Child Youth Governance Group – disestablished Feb 2011. Midlands Health Network – member of SLAT for project development stage. No on-going relationship from this. They appear to want to be the sole provider of primary health in the region. No opportunities tabled for working together. The difference is engaging with clients, then

giving them the information. All providers working together on initiatives will see the most change – e.g. smoking cessation.

- We are a frontline process used to help families/whānau reach their goals in whatever area of need exists, e.g. health, financial, education, children’s behaviour, etc. Because we have a well-known, excellent track record of helping agencies and families so duplication and gaps are addressed, and because we save organisations a lot of time and effort, and because we provide hope to the families, we are valued and referred to a lot. Our continued success in supporting health care providers and others to understand the present needs of the family, we continue to have positive interactions, attendance and referrals from the relevant agencies in our area.
- We are a group of parents passionate about homebirth. We offer a support group for parents – to attend morning teas mainly. Though we are also involved in an antenatal class that, as mentioned earlier, we are becoming more involved in managing and we work with one midwife practice to run this class to a high, professional standard. This midwife practice is the only group that we actively collaborate with, otherwise we are independent and function in a stand-alone capacity, under our national umbrella group. We are becoming more involved with the local PHOs and CDHB through a new group that has recently (amidst earthquakes) started, addressing maternity needs in Canterbury into the future. We are a voluntary group, not specifically trained in what we do – except that the majority of us have had at least one homebirth and want to allow others to do the same.
- We do not have a relationship at a ground level with PHOs. We do not appear to have a representative on the PHOs as this appears to be specifically designed to deal with matters of health delivery and does not have a holistic focus on community health, including social services, education and other ancillary services involved with families. Value would be added by including these other services into the PHO connection as this would provide a wider range of information for decision-making to be established and collaborative relationships can improve service delivery and client outcomes.
- We have a bottom-up approach and our collaboration is driven by the needs of those who use our services. Try and reduce the competitive model of funding that flows on into the delivery of services.
- We have a multi-disciplinary team in our Elder Abuse and Neglect Prevention Service that meets monthly as an advisory group to the service. We probably work more closely with CMDHB, rather than PHOs, but would like to have a more involved collaborative relationship with PHOs in our region.
- We have attempted to provide more brochures and information to GPs and PHOs. We have strongly communicated the benefits of working from a peer support model. In the future we would like to see peer support given a respected place in the list of strategies that support recovery and resilience.
- We have built relationships with medical professionals and nurses over the past 5 years to enable us to work collaboratively to provide educational and supportive resources to the breast cancer community. It takes time, people are busy, our work is volunteer-based.

- We have constantly disseminated PHOs, GPs and specialists, information on the latest research, treatments for ME/CFS. We have at times run lectures at the hospital for their information. Better communications with NGOs would help improve patient care.
- We have noticed that families have truly valued the input from the brief Intervention service that the PHO provided. More nurses working within GP practices, along with more sessions would be an advantage.
- We have worked through AHPAF to raise awareness of issues. The DHB directors of Allied Health, Technical and Scientific are represented in that Forum, and it has been good to take concerns there to have them worked through. Podiatrists have been arguing for a long time for independent prescribing rights. Our practitioners have the training and competence to prescribe within their scope of practice. If a client with diabetes arrives for their regular foot care, and an infected lesion is noticed by the podiatrist, a course of antibiotics can only be recommended. This results in a trip to the GP (if the client decides to go), and an extra consultation fee. There can also be time delays for treatment, which can result in further complications. The next Podiatry Conference in New Zealand is to be held next year (September) at the Aotea Centre in Auckland. It would be good if someone talked at the conference about how podiatrists can work in a collaborative way with PHOs.
- We need more doctors in the rural sector, we need more available appointments. The local medical centre has patients see the nurse before getting an appointment to see the Dr. This is most unsatisfactory and is stopping a lot of elderly people from even bothering to go to the med centre. We get lots of complaints about this from the clients we take to specialist appointments. It appears many things are not dealt with as soon as they should be causing a worse problem in one case we know of – possibly death of the client. Our local service is really suffering through lack of medical professionals and then when they get in a locum, the client is annoyed because they don't know the background and this appears to the client as being unprofessional. Many of our local people have gone further afield to other doctors in order to get some attention. It appears that in the rural sector you take the risk of not getting medical attention – this needs to change.
- We provided free screening and worked collaboratively with a PHO that had a large number of at-risk patients. This enabled us to identify and communicate the concerns with the PHO staff and form a good relationship for further communication.
- We see opportunities for maintenance dialysis treatment in the community to be 'normalised' by co-locating haemodialysis units with PHOs, as is currently being explored in Auckland – or setting up facilities for dialysis patients who do not need assistance with their dialysis, (i.e. are home haemodialysis trained, but don't have a suitable home environment). Dialysing in the community rather than a hospital unit improves and promotes wellness and independence. An added advantage of working with PHOs would be greater understanding of renal failure and all its associated health/emotional/social issues by primary healthcare staff, and consequently more effective healthcare for patients. There is a great need for smaller community-based dialysis units to reduce travel to and from dialysis three times a week – currently we have people in Gisborne, Opotiki, etc having to travel to Hamilton for dialysis, as the small local units in Tauranga and Rotorua are usually full, and even the trip from Wellsford to the new North Shore dialysis unit is still a long one. We understand there is a GP practice in Wellsford interested in providing dialysis facilities for local patients. It should be possible to explore

options for rural patients in the Waikato/BOP/Tairāwhiti area along similar lines. We have only worked in the Waikato/BOP/Tairāwhiti area since March last year and have not yet had the time/resource to make local contacts, but are hoping to do so in the future. Until earlier this year, patients in Kaitiā travelled to Whangarei three times a week. The newly-opened Kaitiā dialysis unit, although still hospital-based and staffed by dialysis nurses, has no renal specialist on the spot, but there is a Telemedicine link with Whangarei Hospital. This could well be an option for PHO-supported small local units. Our Society has an unstaffed community dialysis house in South Auckland catering for 14 home haemodialysis trained patients who come and go for their dialysis, which they manage unaided. While this is run in conjunction with the CMDHB renal service (i.e. not primary healthcare), there is no reason why this could not be done equally well by a DHB renal service in partnership with a PHO. Some years ago, CMDHB had a two machine, one room facility at Pukekohe Hospital for four home-trained patients run on the same basis – because there was space, and because there were local home-trained patients. This was discontinued because the local patients ‘moved on’, but a similar setup could well be a solution for many other locations – is cheap to set up and easy to manage. Community dialysis close to home, with minimal staff assistance or, for home-trained patients unstaffed, would be a great incentive for patients to take responsibility for their own treatment. Local GP backup promoting and practicing this self-care philosophy would benefit patients and the community greatly.

- We would like to work more collaboratively with other organisations, DHBs, PHOs etc. Each of these organisations use pamphlets that they have developed ad hoc and they are not often up-to-date or correct. We would like each of these groups to work with peak bodies for different conditions (e.g. continence, diabetes, Alzheimer’s, stroke), and develop one lot of information that is used by each of these organisations.
- We would welcome more input into patient self-care models for managing cardiovascular risk. We are currently working on a national level with primary care to pilot some new resources and once these resources are widely available, it would be great to help promote the uptake at a regional level. A lot of our regional emphasis is on health promotion, which is not the priority of primary care, so we don't have a huge involvement. We often find the definition of health promotion within primary care quite limited. Health promotion is often viewed as education only, and promotion at a population level is commonly interpreted as 'group education', so there are not always joint objectives for us to work with primary care. However, we are happy to help wherever possible.
- Whānau Ora is a good concept, but us in primary health (from my experience) are too over-whelmed with the basics because of staff shortages, staff changes, pay issues and huge workloads, to have the energy/time to give these questions much thought.
- Whānau Ora models of care implemented by [us].
- When we have provided a talk to the service on what we do, then we get more referrals and the relationship is built. After we do a presentation (e.g. to midwife group) then they ring us with problems and concerns. Too many people are unaware of what we do, so do not refer people to get the support they need. Now we have spent the time on contacting hospital and talking to specific groups, referrals are made much sooner, which is far better for the client. One problem is we have limited funding – so not good relationship if referral implies we can give them things – but if they know what support

we give, this is great. We can then contact them back for queries people have – many are frightened of the health service, but if we know people, we can make the enquiry for the family. Also, we need a new word for support – people imagine it is crying, desperate people, when in fact support can include this, but usually is information, empathy and practical help.

- Willingness of GPs (in particular) to be aware of local services. Repeatedly have women who eventually access our service, who have had GP care and often medication, but not referred for other therapies. Women frustrated they didn't know of the service earlier. Funding support from PHO to support our mutual clients with care/support (e.g. transport, home aid) that is currently gate-kept by GPs; this funding should be available to the clients without having to pay to see a GP to access it.
- Willingness of those who work in GP practices to learn about what we do as Māori Health providers and understand that we all have value.
- Worked thru medical social workers to have patients' needs addressed. Have social workers attached to PHOs, which could link to NGOs outside the GP practice.
- Written letters of concern to PHO in collaboration with other NGO field workers. More recognition of the work done by NGOs.

Comments from government bodies (e.g. DHB public health staff, MSD, etc)

- Again, the Coast is unique in terms of the majority of general practices and primary health services [being] run by the DHB – it would work well without the PHO draining the financial resources and duplicating services. [Our] Rural Nurse Specialists are providing remote clinics so people who live remotely have access to health care in a timely manner. We are currently in the process of developing a business case for an integrated family health centre in Buller. [We have] been functioning as an integrated health centre for just over two years.
- Better communications with Primary Health agencies that enable a more seamless path of care. Have been to meet with these organisations to explain my role and how we can work better together. Looked for common ground in the care pathway that we can work from to develop a better system of care for clients.
Future changes: Better communication from GPs and more willingness to accept information and suggestion from outside agencies. More timely interventions from Primary Health Care agencies to promote and improve individual clients' health, more collaboration in instituting beneficial care pathways.
- Education is offered to NGO and PHO staff from DHB Mental Health Educators, to assist them to understand the issues faced by MH consumers. Many NGO and PHO staff attend our workshops/education sessions. Many of our mental health staff also offer education direct to these providers, this assists with relationship-building, as well as promoting a collaborative relationship with shared clients etc.
Future changes include: more education and support for GPs and Practice Nurses on the management of clients with MH issues, where and when to refer to etc. More education and support for NGO staff – many of whom are 'support workers' who require more training – this would help to promote retention of these staff (as well as increasing their salaries – to attract and retain a high calibre of good quality staff). This would assist in developing early intervention screening, reduce the need for re-admission due to

relapse. MH clients require assistance to manage symptoms of mental illness, but if the staff delivering the care have a lack of knowledge/expertise themselves, then services and clients will go backwards, as opposed to forwards.

- Focus on common high level objectives. Identification of suitable indicators – establishing baselines and monitoring progress.
- Governance that have not-for-profit motives that put people first and which share common philosophy consistent with the WHO Declaration of Alma Ata on Primary Health Care. Reducing the influence of business for-profit models of independent practitioners associations. A government that is committed to affordable health care for all and public health programmes.
- Have consumer representatives on the steering group.
- Long-term iwi relationships – whānaungatanga has made collaborative projects easier to discuss, develop and implement. We are both Māori providers who have a clear understanding of our core business and the roles we play in whānau ora. We're in a recession – we all need to do more with less!
- Maintaining clinical networks at ALL levels – with specialist and NGO and primary services working collaboratively – especially developing, supporting and maintaining clinical competence. Our country is too small NOT to collaborate. National credentialing of clinicians – RNs and doctors across all levels – we already have one for specialist medicine and National Diabetes Nurses (through the NSSSD). What makes a real difference is the networks and relationships developed – these can be enhanced by a collaborative philosophy, expectation within and across clinical leadership, support for initiatives from managers – and having clinicians actively involved and leading services.
- Managers insisting these relationships are an important piece and need ongoing work to manage/ maintain.
- My role with the organisation is to engage and collaborate with primary health services in the community to enable both involvement of the health services with a particular Work & Income office – in an attempt to better meet the needs of the clients. I have the ability to access the primary health services that are appropriate to client needs.
- Our environment (prison) can be seen as outside the normal health channels. We try very hard to stay connected to the local health environment. It is important that we are seen as part of the health community and developing relationships is our best way to stay connected and support prisoners to better health outcomes.
- Our model is a collaborative case conference model. A key lever is having the family at the centre of the process – they are motivated as they are given ownership of the meeting (i.e. the goals for their family, which agencies they wish to have participate, what information they would like shared). The process is voluntary for them, they can exit at any stage. A key benefit perceived by families is that they only have to tell their story once to all the services they are working with. This means less hassle and fewer meetings for them to sort out their issues. Furthermore, they get a better, faster service, as agencies find they get to the bottom of the family's problems faster and are better co-ordinated and linked into each other when delivering services. This includes support with non-health issues (e.g. housing, truancy, child behaviour, parenting, finances, budget management....). There is no restriction to the agencies who may be involved.
Future changes to add value?: Systematically connecting with and making referrals to the

Strengthening Families process in your local area. Visit www.strengtheningfamilies.govt.nz for local information. Training your own staff as in-house Strengthening Families facilitators to lead collaborative case processes. Dedicated facilitators for the disability sector – this sector is difficult for families to navigate and a major source of confusion and stress for families, especially when managing children with very high needs.

- Perhaps family nurse case managers (where there are large families 10 + living in one house). Looking at skin health (if skin infections) assisting through say a NGO like Rotary to provide a linen service. Involving a nutritionist advising on healthy eating. Planting a garden, shopping around for the cheapest fruit/veges. Budget meals. Cooking demonstrations. Involving Plunket to ensure good child care. Implementing stopping smoking programmes. Implementing Green Prescriptions. Instructing re safety tips in the home. Involving them in programmes like ‘parents as first teachers’. Suggesting family outings using the public parks or joining sports groups. Looking at cheaper transport like cycling. Arranging all medical appointments at similar times. Arranging appointments that coincide with public transport. Encouraging the use of the free health buses. Involving schools and public health nurses.
- Personal relationships are crucial, I believe, to making things work for the client. It is up to the clinicians involved to make themselves known to each other, so that collaboration can occur. When we were not such a busy service, this was easier to do – as community nurse, I always attended the monthly clinical meetings at the practices within my geographical area. This enabled the whole wide team to see and meet each other, referrals flowed easier, patients were seen sooner. This seems to have been given away over the years. In part this has to do with patients not being registered with a GP so ‘no-one’ to talk to and has been furthered by the difficulty experienced in actually talking to who you need to over the phone. There appears to be many more layers of people to get through before you can actually speak to the GP. It almost seems like everyone is waiting for someone else to take responsibility for making something happen. Within DHB land there are heaps of opportunities for our staff to work with NGO staff in terms of support and education so they can deliver the best care to the shared client, but there is the notion that the NGO gets paid for this so why can’t they do it. This attitude is counter-productive. Within our DHB we have over recent years ensured that NGO staff have access to the hospital in-services and have also catered specific days for their identified learning requirements. We are also more recently identifying staff in key DHB positions to work specifically with a NGO or a group of NGOs. I think the key levers/triggers need to be around the particular patient or patient group – that response from the DHB needs to be timely, appropriate and supported. One key initiative that I think will work well is to utilise more clinicians who work across the primary/secondary boundary. Nurses are well-positioned for this in terms of CNS/NP roles. I would like to see DHB nurses working in GP surgeries to deliver care to the patients and also to up-skill the existing GP team in respect of MH&AS issues. Improving this interface will benefit the client immediately, with other benefits realised over a greater time period, with potentially fewer inappropriate referrals to CMH, less waiting time etc.
- Relationships, and structures that facilitate across sector collaboration, protected supervision time and time for health professionals to meet together to connect re shared cares.

- The greatest concern I have is that the need for integrated care in community settings, which includes timely access to appropriate home supports and timely access to assessment for equipment etc, seems to not have been considered by PHOs or DHBs as an essential aspect of developing integrated models of care – particularly for our ageing population. There appears to be insufficient investment in Community Allied Health Services (in particular OTs and PTs) – after all, they are the professional groups who have the skills and training to lead the way in well-planned, community-based supports if they are to be integrated with social models of support and care (habilitation and rehabilitation). This is necessary if we wish to support older people to remain in their own homes – or at least avoid hospital admissions and unnecessary admission in residential care settings. The focus now needs to move from strong clinical intervention to well-balanced, community support and, I fear that DHBs and PHOs do not understand the need to consider restorative and social models of care as having much more relevance to people with impairment living in communities.
- The organisation is working closely with all partners in a variety of ways and in each locale to improve clients’ access to health and social services.
- The provision of a ‘connector’ or ‘communicator’ to help ensure each agency was working effectively and not duplicating or even undermining work being done by other agencies (inadvertently usually). Social workers attached to medical centres. Better after-hours funding for primary health care services.
- Universal screening of thyroid and ferritin blood levels of all pregnant women presenting to GP services and upon initiation booking with a LMC. Early referral (early pregnancy) from Primary Care providers for clients with a known Bi-Polar Disorder.
- What makes a difference is the relationship and professional trust that has developed throughout this collaborative project. Through this project, patients referred by the specialist wound clinic (mainly venous ulcers) to tertiary vascular services receive timely appointments because the vascular service knows that the patient’s assessment has been thorough and complete, therefore a referral to the vascular service must indicate an arterial problem, which cannot be treated in the community. What would make a difference is the ability to access all patients’ notes, not just the MedTech notes of the patients who are registered with the PHO where the clinic is located. What would also make a difference is the patients being able to access funding for ongoing compression hosiery. The patients we are treating are under 65 years and 75% are male and 44% under the age of 55 years and 17% under the age of 45 years. The ongoing hosiery that the patients require are expensive and the funding is only for one pair for life.

Comments from commercial providers (e.g. private practice, specialists, etc)

- A lot of our clients have complex health issues and complex social situations. It is clear that many of the barriers to improving their health are often social ones – trouble with their WINZ allowances, problems with housing, problems with misunderstandings to do with the billing practices by electricity/phone companies. These people often lack the self-determination and skills to stand up for their rights and need someone to advocate for them.
- Basically this is my message: There need to be centres of excellence for small specialties and increased funding for them. It is a joke to think that getting things done in primary

care can be done when the GPs have already referred for secondary care. Make centres of excellence – so what, if it is a bit of a journey to get there – in lots of countries people travel miles for good health care.

- Building good relationships, timely communication – electronic helps lots – rapid pick up of referrals/strike while the iron is hot and the mobile no. is still connected. All sing the same song – everybody clinical compassionately approaches cessation initiatives. Organisation needs to share information and a few cups of tea. Need a good philosophical base to sort out priorities in a private business – explore where profit sits with collaboration and understand they are not mutually exclusive. Personalised service seems important – people don't like being 'processed'.
- For these organisations to be more open to receiving communications/ideas/have discussions, to provide a more 'integrative' health system, making available to patients/consumers, natural therapy options, that are of a 'complementary nature'. Currently there is still great resistance from the decision-makers in these organisations, and also from the health care practitioners, to natural therapies. We believe it would be beneficial for PHOs etc, to be willing to receive educational materials/discussions/seminars/information events to foster greater understanding of natural therapies, those that work within an appropriate 'scope of practice' and how these therapies can greatly assist, not only the health of patients, but also their progress through traditional medical treatments, and also provide a cost saving to the tax payers who finance health services in this country.
- Fragmentation of mental health services in Auckland is a big problem with PHOs, DBHs, A+, contracted NGOs, voluntary sector and private sector all offering services with different funding and criteria – very complex even for people working in the field to navigate and get clients to the right service. www.healthpoint.co.nz is a very useful resource but the lack of transparency, especially around contracted NGOs, is a substantial access barrier.
- I have answered some of this in previous sections but, changes required. Instead of stupid bloody surveys sent into our practices asking what we think of priorities they (PHO governance groups) have already identified (read: decided on, but have to demonstrate 'collaboration') – how about they get off their backsides and walk into the clinics and ask the clinicians (because, according to the MOH – we should be leading health care services!) what they see as problems, what solutions we have implemented/dreamed about. Might actually create some ownership of the PHC system for those working in it and go a long way to fixing some really basic barriers to achieving greater health outcomes for those most vulnerable in our society!!! Some of the solutions are so bloody basic...and yet apparently so bloody 'invisible' to those who make all the decisions!
- I have provided holistic rehabilitation packages to ACC since 2001. Their model of care is an excellent one whereby we work with the client in the client's own home, community or workplace. There is no point in expecting many of our patients to come into surgery or clinic – many won't. Even when they do – people can pull themselves together very well for a few minutes. GPs only get to learn of whatever the patient chooses to share with them. By establishing rapport with the patient and family/whānau in their own real messy world, we can identify change and proactively manage these patients avoiding wasting valuable secondary level resources. I have adopted the ACC model of care to my work with patients with HD.

- I haven't seen it here, but in the UK services are tailored specifically for Deaf by Deaf. A kind of motto such as 'nothing about us without us' exists, so in all areas of health care the uptake for Deaf and hearing impaired is greatly increased. They get a sense of ownership and of course it is conducive to their language and culture. New Zealand Sign Language is NZ's second recognised language, yet we hardly ever see it in a practical sense giving back to the Deaf community.
- I know of no levers or triggers that we have used to enable PHOs etc to develop specific models of care. However our training programme (which is based on wellness, early prevention and early interaction, rather than addictions and treatment) has enabled participants such as GPs, PNs and those working in chronic condition management to learn how to facilitate behaviour change in a more time efficient and cost-effective way, without constant duplication and funding wastage. We have specifically researched and identified the barriers and reasons why people choose not to change risky behaviour and, as a result, have developed new tools and resources to assist health professionals for this purpose. There is always major interest in this training, but also a non-commitment from PHOs to cement this as a tried and tested approach for prevention and wellness.
- In the past we have been in contact with the Canterbury DHB and Pegasus PHO, and offered cost-effective and community-based sleep services. In both cases, despite providing some initial service and education, we have been overlooked and our experience ignored, in preference for hospital-based service. In effect, reinventing the wheel that we had developed in the case of community-based sleep services. Politics we suspect as being the driving force! However, we now hold the contract for the sleep services for the Nelson and Marlborough District Health Board, who have been very supportive, and I hope benefitted from our relationship.
- Make a practising community pharmacist representative compulsory on all PHO boards. Appoint a 'Charge Pharmacist' similar to the Chief Medical Officer at the Ministry of Health to inform policy development within the sector. Allow pharmacists to assist with development of strategy to improve medication adherence – this is the biggest opportunity in primary healthcare and it is being ignored. Allow accredited pharmacists to offer funded influenza vaccinations.
- Provide funding to organisations like myself to see those in the community who can't afford to otherwise come. Ongoing support for people in the community is part of our package. So access to our website to gain recipe files, library books, monthly newsletters (which we can now email out) offers nutritional tips and reminders about how to stay on track and updated nutrition information that wouldn't otherwise be available. I would like to see people go through *Appetite for Life* to get a good overview of changes that are necessary to diet and exercise, and then come onto our more specific plan, which moulds the dietary needs to the individual. I also want to take the people who have gone through our programme and offer them group sessions on specific topics on a regular basis, such as offer supermarket tours or seminars on topics like meal planning, staying on track during winter (or earthquakes ha!), family nutrition, eating out/takeaways, building sustainable energy for work – stress reduction is possible with a healthier diet. Also some of our morbidly obese people really needed funding to work with a Sports Psychologist. I managed to get our 60kg weight-loss man a free session with one and it helped him a lot to deal with anger issues that had led to overeating. Sadly there weren't funds for more sessions, but this would really help. I worked with the Wheelchair rugby team for the

What's changed?

What's started?

Some respondents provided examples of primary health care providers that STARTED working collaboratively and examples of what they were collaborating on:

- A new team of managers, so unable to comment.
- All too difficult questions to answer.
- At Community House basic equipment like photocopiers were shared.
- Attending Consumers' General Practitioner appointments as these links are a vital part of our consumers' well-being. Linked in with Māori services to meet the cultural needs for our consumers.
- Auckland supercity legislation forced many social service providers to work collaboratively.
- Building respectful and reciprocal relationships with others, trying to do 'more' with 'less' within communities.
- Capital PHO and non-profit, non-health agency: Te Rito Gardens.
- CCDHB funded PHOs.
- Current PHO – needed more management support. Too many others to mention.
- Depends on the region.
- Early years service hub – joint delivery of parenting education groups.
- East Health PHO work collaboratively with us. Attending client review meetings with Geriatrician.
- Emergency services in rural areas – Ambulance, Police, fire and civil defence.
- General Practice and non-profit, non-health agency: Te Puni Kokiri
- GP services in region changed to be a primary health organisation.
- Hamilton GPs and a list of other organisations.
- Health Care Development Midcentral DHB.
- Hep Foundation and gastro dept at the Wellington DHB.
- Initial difficulty with creating workable pathways with co-existing health streams, has taken some time to collaborate and create, collect relevant data to align.
- Local Māori Providers.
- Local PHOs.
- Masterton Medical Limited, Whaiora Medical centre, PHO Cameron Community Centre, Cole St Marae Clinic.
- Midlands DHBs toward a collective Vision for 2020: tobacco free/tupeka kore Aotearoa New Zealand. Also, through smokefree regional networks, PHOs and cessation service providers, began to collaborate on meeting the ABC target for their region.
- N/A. (3)
- No. (5)

- Not Started. In the practices (medical and pharmacy), they have been working collaboratively for many years.
- On the hospice in my area.
- Otago Falls Programme.
- Others realised the benefits that would be gained by their clients, this spurred collaborative working.
- PHO Business case Tihei Wairarapa.
- PHOs: Once the PHOs were integrated into one PHO – prior to this we never heard from them. Others: We are now working closely on moving to prescribing.
- Practice nurses are more aware of the services that we provide.
- Primary and secondary services collaborating by networking and communicating without duplication.
- Raukura Hauora o Waikato and non-profit, non-health agency: Te Kahui Mana Ririki.
- Regional RFP included 5 Māori Health Providers, Public Health Service and the PHO (only 1 in our rohe).
- Reps have started to come to network meetings.
- Several PHOs were amalgamated.
- Since the start of a new service launched 4 May 2011, we are working collaboratively with the primary care provider.
- Smaller PHOs forced by threat of funding cuts – started working together.
- Sought common ground around prevention, promotion, mental health problems.
- Started working with 3x Iwi providers of Well Child Service with mutual clients.
- Tairāwhiti District Health – we have a close association sharing ideas about the best service we can each provide for our clients.
- Te Hononga has engaged with us to do a reducing inequality strategy for cervical screening.
- To review their structure and processes in relation to services for people with mental health problems
- Us (general practice) and Te Papa Takaro (provider of healthy lifestyle services) and mental health services and arthritis educator and Plunket and diabetes services.
- Vibe, Te Pae Pae Arihi, Welltrust, Pathways and non-health provider: CRHS.
- Waahi Whaanui and Tamariki Ora.
- We have been doing this for the past 20 years.
- We were able to find funding to assist with a collaborative project. It was VERY difficult to find funding.
- Whatever has happened, it is still all whites employed in these positions, nothing culturally in place.
- With our Stroke Club to improve our education about current stroke treatment – our Club provided the hospital Stroke team and other staff with educational material on stroke prevention and long-term rehabilitation available through our Club.
- Yes. (4)

- Yes – it’s better than it was a few years ago.
- Yes – Midlands Health Network going well – at this early stage.
- Yes – particularly in the Waitemata DHB region – HealthWEST, Harbour Health, ProCare.
- Yes, some are working together a little more.
- Yes, some developments.
- Yes to a certain degree.
- Yes under the umbrella of the PHO – Services to Improve Access initiative.
- Yes, worked with the PHO.
- Yes, required by service contract to do so.

Service changed

Some respondents gave examples of how the delivery of a service was CHANGED to complement the primary health care services offered by others:

- Advertising and marketing have been key, as is relationship development with other providers.
- Began to establish multi-disciplinary consultation groups around main disease states and invited our participation.
- Both ourselves and the PHO changed.
- By providing an umbrella for a staff member for the above initiative for resettling people.
- Chronic Health courses were offered by Arthritis NZ and so other people with other chronic conditions also did this course.
- Collaboration in common programmes, e.g. HEHA, Smoking Cessation.
- Communication and liaison nurse at prison works with a nurse at the DHB.
- DHB devolved this service to primary care.
- DHB directive for better sooner more efficient services and downsizing 12 Māori providers to 4 across the whole DHB.
- Greater referral networks had to be established in order to meet new demand for cessation caused by population-based ABC health promotion.
- Immunisation.
- Improved staff training, with inter-agency collaboration as the catch cry.
- In many of the PHOs, there is a mental health clinician – this has assisted with the early identification of mental health problems. Having mental health clinicians on site has promoted collaboration and works towards reducing the stigma and discrimination associated with mental illness.
- It only provides dollars into their pockets.
- More nurse-led services, standing orders for access to medications, acute care and triage by nurses.
- More sharing of experiences and in some cases spreading of medical workforce across practices.
- More worked alongside.

- NA. (2)
- New Medical Centre opened in Wanaka.
- No. (4)
- No evidence seen as yet.
- Not necessarily. It removed a valuable service from our community.
- Not sure. (2)
- Nothing noticeable.
- Offered services in community, access supported by general practice to encourage uptake, e.g. txtng to remind, ringing, encouraging.
- Ongoing relationship building and communication.
- Presby Support – LINK service now actively functional with good cross-referral and improved health of clients.
- Provided by one physiotherapy centre.
- Providing accessible, affordable health care in different settings/venues.
- Reducing inequalities framework implemented in some practices, but slow to evolve.
- Reorganising and adaptation of co-existing health strategies to new PHO contracts will take time to attain a positive collaborative approach. Communication in a collective view has assisted the data collected thus far.
- Tairawhiti District Health amended the referral process and Gisborne Stroke Support Group made an input.
- The social worker said she now had a better understanding of what stroke patients and their families have to deal with after stroke. And the Stroke team plus others at the hospital are more aware of the services and educational materials we offer in Wellington.
- Valley PHO yes – others you have to access for the older person, i.e. transport assistance.
- Waahi Whaanui delivers Family Start with a focus on young mothers having children and Tamariki Ora provide wellness checks for the babies.
- We complemented GP services by taking community services to people's homes, community events etc.
- We regularly keep the GP and specialists informed of changes in the health or behaviour of their HD patients.
- We started using the [Everybody website](#) to locate GPs expressing an interest in caring for people with mental health issues.
- We work closely with mental health services to prevent mental health consumers from becoming unwell and needing those services, but also can direct our consumers to these organisations if needed.
- Yes. (5)
- Yes, we put our services in the area of the community where there was a gap, e.g. Aranui.

New service

Some respondents identified a NEW SERVICE that was created to complement what other primary health providers offer:

- A nurse-led primary care clinic within the Work & Income Community Link centre provided by the PHO.
- An additional service that met the needs of the particular community/family.
- Community house services listed above.
- Community PT – especially following fall events with clients.
- Connecting Communities Programme.
- Counselling.
- Green prescription to encourage people to be active to combat health issues.
- Healthy living included gardening projects, youth programmes, older people's programmes, Hip Hop, Pacific aerobics, Pacific art and craft, plus nurse-led clinics, arthritis, asthma and cardiovascular. Free health screening provided at all events organised by the service.
- Holistic well-being workshops.
- However for (mostly the less well-off) it provides a feeling that the service cares for them specifically and holistically.
- Massey Chronic Conditions Psychology Service.
- Maybe.
- Meals and housework support for struggling women.
- N/A. (3)
- No. (4)
- No – transport to access appointments has always been an issue for the older disabled person.
- None.
- Not necessarily. The new service was an old service revamped with a smaller budget and tighter constraints.
- Not observed.
- Not sure.
- Nursing services.
- ORA at CCDHB, connecting older people and rehab services more collectively between acute and primary care.
- Ora Toa PHO Community Smoking Cessation Service.
- Palliative care nurse practitioner (NP) role within the organisation.
- Referral pathways streamlined in some regions for greater efficiency.
- [Right Services Right Time](#) established in the NGO sector to provide a single point of referral for anyone wanting to access a social service.
- Service has been around for a number of years, however concentrated marketing has been effective and beneficial all round.

- Tairāwhiti District Health continued its funding to [us] confirming that our service is so very important to Stroke Survivors.
- Tell me what it is I'm supposed to be doing cause I do not know?
- The change made a new organisation for palliative care.
- The focus was on efficiencies, rather than the unique services each provider delivered to their communities. Nor was there any evidence of planning or consultation on unique community needs against provider' specialty services or the mitigation of risks and impact moving a primary health care workforce – mainly nurses, in the initiative's service planning.
- The proposed changes to prescribing rights are positive. However, a barrier remains while one health professional (e.g. a podiatrist) must seek approval from another to do work they are fully trained to do.
- There was no other service like ours here. It's a no transport area, no way to get to health care providers.
- To better improve client access to health services, more accurate assessments, correct referral structure, enabling the client to understand and lead a more independent health regime where he/she has attained responsibility for their health issues.
- Waikato Plunket Funky Monkeys Roadshows. Fun positive parenting messages for families across the Waikato.
- We actually identified what each of our strengths were and focused on this and the outcomes for patients.
- We are the 'gate at the top of the cliff' not the 'ambulance at the bottom'.
- We started a social drop-in for Pacific people with experience of mental illness. It complements the Pacific Trust Mental Health Team work and expands our service base. We gained the contract from CDHB to provide Advocacy and Peer Support for people with addictions experience. We gained a contract with the CDHB to provide consumer leadership and network support for people with mental health or addictions experience.
- Yes. (3)
- Yes to a certain degree.
- Yes via the CPHO.
- Yes. In Nelson, I now offer a service to Primary Health providers that was not present before.

What stopped?

Some respondents gave examples of things they'd STOPPED doing because they identified duplication and now refer people to another provider:

- Between Public Health and our service, we agreed that they would provide sexual health advice to youth and we would refer promptly on identification of need.
- Duplication has continued.
- Duplication identified in 2005 and stopped, DNs as generalists vs. specialist palliative care nurses.

- I don't know.
- Important for us to research and consult communities prior to new project to avoid such events.
- Incorrect client status. Assessments incurred referral 'stuff ups' doubling-up caseloads. This has been identified and stopped.
- N/A. (3)
- No. (4)
- No, not at all.
- No, we stopped because there was no more funding to reach the sector of the community who couldn't otherwise pay.
- No, where PHO could not provide the service, we did – other PHOs do not offer it unless pressed and limited to 4x.
- Not aware of this other than merging of PHOs to reduce number.
- Not necessarily. Due to isolation, distance to travel etc duplication can't help but be the choice in our area.
- Not observed. (2)
- Not sure.
- Nothing has stopped. Contracts are being withdrawn and providers continue to receive a monthly statement of contract carry over, which impacts on workforce sustainability and morale.
- Our service in this geographical area stands alone, so therefore no duplication is identified.
- Packages of Care were able to initiate PT units to provide the Physiotherapy.
- Part of our ongoing role is to look for duplication so that it can be stopped.
- Some site management services now more centralised with larger organisation. Closure of at least 2 clinics.
- The hospital was referring patients on to our breathing groups after their initial treatments were finished. Does not appear to be happening any more. Their patients are just staying on.
- Transport.
- We may give up some of the healthy living programmes due to funding cuts.
- We stopped offering a Women Only group and refer people to the Salvation Army Wahine Whaiora programme and the Manuka Cottage Women Only Day.
- Worked together to achieve a common goal by pooling funds and requesting community funding as a group.
- Working with Careerforce, Alzheimer's NZ and Carers NZ to identify duplication of resources with view to streamline.
- Yes. (2)
- Yes, the service became a one-stop-shop.

Information improved

Some respondents gave examples of the way information is COLLECTED and SHARED was IMPROVED by:

- 12/52 reports from the providers.
- Absolutely, we provided reports all the way. In fact, we were required to provide too many, which cost us more (\$) in admin time.
- Access to electronic records, e.g. Concerto & Community on Line.
- Acknowledging the PHO service delivery role(s) of each individual health pathway.
- All general practices have gone to the same PMS, which will and does link with the DHB system.
- An entirely new system of ABC measurement in order to monitor and target levels of performance. Greatest performance came about when great buy-in from GPs achieved, through improvement/development of communications strategy.
- Becoming members of Platform, providing regular updates to the CDHB newsletter editor, contributing to the national consumer newsletter About Us.
- Better networking and continually attending workshops and seminars.
- Between the newly established Health of Older Persons Team, we agreed to share names of clients who use our service and/or require current interventions.
- By increasing our communication and interaction with a wide range of linked services.
- Coalition meetings.
- Commencing the MoH PRIMHD process.
- Communication is made with the GP or referring agency with every private client seen.
- Communication and referrals to the DHB.
- Consent forms introduced for the sharing of family information at multi-agency meetings.
- Contributing to a national data collection and have new requirements by funders and we share info for benchmarking.
- Creating a database system that aligns with our iwi database – can incorporate MedTech and profile.
- Don't know.
- Having a common patient register.
- Health pathways website.
- Increased collaboration and sharing of knowledge/skills through, for example, training opportunities provided by our service around cultural competency.
- Interfacing with IT– e.g. electronic referral forms to avoid transcription errors.
- IT systems.
- MedTech available, able to access lab results.
- MedTech.
- Meetings held with Tairāwhiti District Health Planning and Funding and Ward Medical professionals continues.
- N/A. (4)

- Nil.
- No.
- No change.
- No, however as a Māori provider we have invested primary health care leadership with the DHB re nursing service specifications to meet the national Whānau Ora outcome measures, reporting templates, targets against best practice guidelines.
- Not as yet.
- Not observed.
- Not sure. (2)
- NP direct communication with GPs; NP support for nurses to improve assessment information and communication with GPs.
- Nurse inter-disciplinary collaboration.
- Primary health members more willing to share information about clients.
- PRIMHD.
- Public health nurses started tracking referrals on the general hospital patient management system, which enabled other services to see that Public Health Nurses were involved and to refer back to them.
- Relationships were developed between the two organisations through process challenging and enhancing the communication between the two organisations.
- Reviewing service specifications.
- Staff training.
- Strengthening relationships and better communication.
- Talking.
- The hospital sending the GP e-mail communication regarding admission and discharge in a timely way.
- Using the InterRAI suite of assessment tools.
- Utilising MedTech, acknowledging referrals.
- Yes, we are much more aware of the importance of data gathering and the systems in which to do this. Sharing information is still an area that is difficult to get results.

Barrier identified

Some respondents noted barriers to collaboration:

- A sense of ownership of service users, a sense of being effective and not needing to do more.
- All current barriers seem to be earthquake-related, with some organisations still being homeless, the roads being difficult and the clients' needs much increased.
- As a need to offer the client satisfaction and excellence. To get better client feedback.
- As lack of communication and thus knowledge by many working in the hospital setting. about stroke consequences for families, and services available through our [NGO] in the Wellington community.

- Attending hui to create change often means key staff are out of field.
- Barrier is poor communication between linked services.
- Buy-in of workforce.
- Clinic/practice identity that was long-established. For-profit vs. not-for-profit motives.
- Concerns about giving information before the purpose of the information-sharing was 'out on the table'.
- Different priorities; competition.
- Distance, funding, isolation.
- Don't know.
- Funding.
- Funding appears to be a barrier as to who/which service does what. I think there is a general perspective that primary is being funded to deliver MH&AS, but is not doing a good job. Not knowing the contracts and expectations makes decision-making difficult for clinicians.
- GP still knows best. 'Clinical' = GP/Medical model.
- GPs and PHOs have high volume caseloads and little time to attend collaborative processes outside of their own workspace.
- Health services were unwilling to let go or accept change.
- Insufficient funding to ensure implementation, fidelity or follow-up to ensure confidence levels from the training were assured.
- Lack of funding and limitations of contracts, time.
- Lack of funding to develop collaborative approach.
- Lack of funds to allow sufficient future planning of admin resources and personnel training/overkill in reporting.
- Lack of knowledge and awareness of MH issues.
- Lack of relationship has been identified as a huge barrier. Between both governance and management and staff level. Limited physical space is also a huge barrier, with many groups operating over and above capacity in their present physical spaces. Physical space is very determinate in what can and cannot be done. For many years we have tried to think outside the square and operate with what we have, however, we simply cannot do any more in the present physical space we have. Money for capital development is almost non-existent in the disability sector and we have to work very hard at raising capital – this in turn takes us away from the primary purpose of the organisation.
- Large workload of many GPs, and subsequent time pressures.
- Limited resources (e.g. funding for staff).
- LMC's unaware of contract obligations/referral to Well Child timelines etc. Operating under different contract specs during 2010–2011.
- N/A. (4)
- No.
- No, no meetings took place if they did I am still to hear about them.
- Non-engagement of GPs.

- None of the services communicate/collaborate as they used to, everything now goes through DHB first.
- Not knowing enough.
- Not on at an organisational level.
- Not sure. (2)
- Often the PHO does not allow staff to participate in education due to funding issues.
- Once we established that we were here to stay.
- Paperwork+++, different funding streams, different expectations, lack of experienced staff.
- Patch protection and concerns about contracts.
- Personalities and siloed structures, including misunderstanding of each other's roles and past negative experiences.
- PHO.
- PHO practices are too busy to engage in new strategies. High workloads.
- Poor two-way communication.
- Reluctance in sharing information from DHB mental health services to NGO mental health services.
- Sharing of information.
- Silo effect.
- Some barriers are around support with a little funding that might make a big difference.
- The ownership model of general practice – we changed this and I am a co-owner (as a registered nurse).
- The PHO is excluding community pharmacy/pharmacists – it is expedient that they use their Facilitator Pharmacist to 'tick the pharmacy box' meaning there is little understanding of the bulk of pharmacists.
- There is still some resistance from some GPs to work collaboratively.
- There was a fear of job loss.
- Time shortage.
- Time taken/required to collaborate for busy services.
- Understanding of clinical hypnotherapy as a modality; perceived 'competition' between conventional and complementary healthcare modalities.
- We were unfortunate not to have had one of our contracts renewed and as a result have lost experience of two staff members carrying out important access to services issues.
- With the withdrawal of contracts and lengthy wait periods in regards to new contracts; and those contracts have 1 year time frames and no resources to provide the outreach capacity of the services we deliver. Funding covers FTEs.
- Yes. (3)

Barriers overcome

Some respondents commented about overcoming barriers to collaboration:

- Accepting a fixed-term contract that combined all health-related services and workforce for the next 12 months. The BARRIER has been reduced, however performance against targets with no resources to actually deliver will remain a medium to high financial and sustainable workforce risk to the organisation.
- Agreement about the purpose of information being to provide better care and trust in the individual nurse due to longstanding previous association.
- Attempt to visit practices to explain our service – GPs tend not to attend; practice nurses more receptive.
- Connect via IT systems.
- Development of hub service centre model (still in development).
- Don't know.
- We have a 15wk programme for weight loss patients but got funding for 5 wks. So we just kept going and offered free weight checks to everyone and website support through newsletter, recipes etc. Those people who kept with our programme continued to lose weight. One man lost 60kg within the year and a woman lost 92.3kg!
- Focusing upon the long-term gains for public health in key messages from a population approach to cessation promotion.
- Going to these services, identifying key people to work with from those services.
- GPs provided with direct-dial numbers to contact at Work & Income.
- Having not-for-profit governance, funding to front-line services rather than to management.
- Meeting face-to-face with these organisations and building trust, relationships and knowledge of their services.
- N/A. (3)
- No. (2)
- No barriers exist as people talk to one another, therefore no patch protection.
- No, distance, isolation and funding allocation is always going to be an issue for us.
- Not needed.
- Not observed.
- Not sure. (2)
- Not yet identified.
- NP role has CONTRIBUTED to an easing of pressure for GPs in some instances and improved clinical communication.
- PMR (Performance Monitoring Reports) data collection is imperative to overcome any issues to maximise trends.
- Prioritise collaboration higher for clinicians, increase ease of referral by introducing electronic referral.
- Sort of.

- Support was given with overdue lists. This helped to some degree to update patient data on screening in the clinic setting.
- Tentatively overcome by pooling resources, but mostly by people who cared enough to donate to our project.
- To a certain degree.
- Transparency in dealing with whānau, in not being the 'scapegoat' for whānau who could not get what they wanted from either organisation and using this to create 'mischief'.
- Trust by explicitly building relationships.
- We continue to send letters and reports to GPs informing them of changes in their patients with HD.
- We have attempted to overcome this barrier by getting personal in our approaches and extending invitations to events that are geared primarily to build relationships amongst the sector.
- We kept relationships and collaboration through Pacific dialogue and formed a consortium.
- When the client said 'my needs were met'.
- With getting to know the nurses and case workers involved with client – and sharing care for the individual.
- Working creatively with the communities to identify solutions to the barriers.
- Yes.
- Yes, to a degree, but more work is required.

New funding?

Some respondents shared examples of ways new sources of FUNDING helped to increase capacity/service delivery:

- A greater number of clients were experiencing the programme in their homes/less falls noted.
- A service funded by the Ministry of Health focussed on chronic diseases.
- ADHB provided some funding for nurses.
- All new funding is from the CDHB this year.
- Community-based funding such as COGS, Local govt, HEHA.
- Continual PMR will identify the actual funding spend.
- DHB funded Medication Utilisation Review (MUR).
- Don't know.
- Funding for free smears was given to GPs and PHOs. This was huge help with collaboration.
- Funding for GP visits to a palliative PT in their own home.
- Funding?
- Healthier, happier clients. Less visits to the medical centre.
- HEHA via DHB, MOH for cessation.

- I'm not aware that there was additional funding.
- Increased public awareness.
- MSD Earthquake funding.
- MSD SKIP funding for Funky Monkeys Roadshows.
- N/A. (4)
- New contract with MOH re Social Detox Services, new PATHS regional contract, increased FTE in DHB area.
- Nil.
- No.
- No funding received apart from clients.
- None as having to manage budget deficit.
- Not at all, no one got funding here.
- Not aware that any additional funding has helped us in any way.
- Not necessarily. I introduced another need to compromise. To take half the apple or get no apple at all.
- Not observed.
- Not sure. (2)
- On-going process of finding new funders although most support comes from the same ones each year.
- Our funding is being cut.
- Our PHO funding has enabled us to offer our rehab course twice yearly as client demand increases.
- Provided a service in an area not receiving a face-to-face service in the past. Has been extremely well-received and appreciated.
- PT-funded nurse consults increase issues to access, hospital-based care becomes the only funded option dependent on eligibility for referral.
- This year we received a donation from our PHO and it was a delightful surprise.
- We are very grateful for the continuation of funding.
- We want to continue to provide this service and to expand it to others who have progressive neurological diseases.
- What new source of funding?
- [Working Together More Fund](#) has enabled us to explore much and realise much about the possibilities. The difficulties to enabling this are still being worked on.
- Yes.
- Yes, but not enough!
- Yes we did. But once the funds ran out and the recession hit, we had to contract our clinics. However I am committed to the new way and have self-funded the development of our licensing model in the faint hope that soon the authorities will catch up with where I am at and recognise that we do have a proven method of weight loss delivery.
- Yes....a new contract has improved relationships.

PHO survey responses

A separate online survey was sent to the 32 primary health organisations in operation on 1 July 2011, but only 11 completed this and sometimes the people doing so were not the most informed about the PHO approach to relationships and collaboration. However, the PHO responses show much in common with the views in the broader survey.

Responses were received from the following PHOs:

- Auckland PHO
- Eastern Bay Primary Health Alliance
- Hauraki
- Health Hawkes Bay – Te Oranga Hawkes Bay
- Kimi Hauora Wairau Marlborough Primary Health
- Midlands Health Network (two responses)
- Nelson Bays Primary Health
- Nga Mataapuna Oranga
- North Waikato PHO
- Southern
- Unidentified

PHO comments about the quality or value of their engagement with their communities:

- As a new PHO, it is our intention to work with all NGOs and General Practice to ensure all needs are identified and met.
- As per traditional rural health service providers [our] practices have a range of service providers operate with them or from the same facility. Mental health and aged-related services are especially collaborative. Audit procedures should catch up with collaborative approach and auditors share information instead of duplicating effort for no added value.
- Excellent support and advice from Māori health providers. Other NGOs e.g. Grey Power, District Council and other advocate and provider agencies have become more involved and constructive as our education and information activities about general practice and primary care have developed.
- Often the conversation is too focused around funding for a single/narrow issue. Real value comes from contribution to strategic planning. Too many groups often in a similar space. Need stronger IT and reporting.
- The majority of our providers come from within their respective communities so we do not contain our relationships to an enrolled population, but by association have one with their communities. We ensure the integration of relationships and participation is clear to everyone.
- There are many NGOs in the Auckland area however most of them work in silos. We have engaged with quite a few to ensure better use of their services and [are] working collaboratively with them to enhance access for patients enrolled with [our] PHO. The barriers are as follows:
 - The weak link sometimes occurs when a relationship has been established and the

person resigns – it takes a good 6/12 before the contact is re-instated.

– Contracts and funding is another barrier that inhibits the service to continue – from a PHO perspective we will refer our GP providers to a service, which had its funding/contract reviewed and the message was not communicated to us or the GP provider. The benefits are developing good relationships so that services are not duplicated for some services that are more stable. However there are still many duplications of services with different models of care and funding models. At the same time, it also offers choices for patients and providers.

- We are a kaupapa Māori PHO.....Our major relationships are with the [tribal] collective. We also engage with marae, community groups, both not-for-profit and voluntary groups. The quality of our engagement is very good; conducted in a whānau-oriented way, which recognises our whakapapa links to each other. Agenda is common.
- We are a PHO with a large enrolled population servicing all these areas. Whilst I have ticked all of the above, it should be pointed out that we receive funding to cover all the above with the exception of Asian health. This is not deemed to be an issue by the local DHB despite evidence to the contrary. We provide services to all primary care patients of all ages, ethnicities and decile groups. Our organisation (PHO) is made up of GP/medical centres, outreach services (including mental health and WellChild) and a residential care facility. We work collaboratively and make internal and external referrals.
- We are a small PHO and we all work together across our services for common goals, i.e. health promotion activities are supported by various services within our PHO. Our PHO supports our services.
- Work with people with chronic health issues. Rehabilitation programmes – cardiac and pulmonary. Provide health care support at work, vaccinations in community settings.

PHO's comments about their collaborative services:

- More flexible funding would help both parties, e.g. we have a collaboration with a Māori health provider to deliver vascular risk assessments through that non-GP provider's nurses. We are keen to do the same with diabetes annual reviews, however the process to vary our DHB contracts is very risk averse and bureaucratic. Worth it though.
- Our member organisation [Māori health provider] delivers primary and community-based services for whānau in the service area. Wider support services provided through the tribal collective. We are generally satisfied with the quality and level of collaboration within our provider grouping.
- The PHO collaborates with a number of NGOs with regard to a broad range of health promotion, service improvement and service delivery initiatives.
- We are not directly responsible for delivering many of the above services. However we do fund these to be delivered on our behalf. We are a PHO that funds other service providers in the community to do all of the above. Integration screening services, linkage services between primary care and social agencies, community development. We are in contact with general practice in other ways. We are a funder working to get groups to collaborate. Other services this PHO provides: clinical pharmacy support, health promotion, community workers, interpretation services, immunisation, long-term conditions, funding for skin lesion services, funding for radiology services, funding for

podiatry services, Outreach services. We support GPs from all aspects – from administration to register management, to payments of GPs to support for clinical programmes such as Diabetes Annual Reviews, Cardiovascular Risk Assessments, Care Plus, PHO Performance Management, Cornerstone accreditation, Pandemic and Emergency Response, mapping of screening codes to read codes in all member practices to improve data accuracy and increase GP incentive payments, liaison with GPs and referrals into clinical programmes, such as well-being (mild-mod mental health issues), outreach nursing, community health workers, dietician referrals, podiatry, reporting of activities for practices within PHO to DHB/PHO Boards and Clinical Governance Boards etc.

- We believe our model achieves this already.
- We encourage NGOs to be part of the solution and have excellent relationships.
- We provide cardiac and pulmonary rehab programmes, funded by the DHB, in a community setting and in partnership with a local iwi provider and also Sport Gisborne. Referrals come mostly from secondary services but also from general practice. We write to each patient's GP at the beginning and end of their 8-week engagement with us and also during that time if there are matters of concern (e.g. blood pressure consistently over or under target, recurring angina). The importance of good engagement with and trust in their GP is covered in the content of the programme. Very interactive, some of our clinical staff work alongside general practice staff in their clinics at times. Also supply education sessions for practice nurses.
- When planning services to be delivered to identified communities and populations – it will be in the interest of all, to get all stakeholders around the table to ensure all parties are able to contribute and work in a smoother flow (collaboratively). Often services are delivered in isolation with little thought on how another service could integrate with the current model or service, e.g. mental health, family violence and child health providers, drug and alcohol services should work together to reduce the rates of abuse.
- Working with local councils to plan health and support services, e.g. positive ageing policy.

PHOs described their most effective collaborative activities or provided brief details about relationships with other NON-PROFIT NGO HEALTH providers:

- Health Housing Initiatives. Transport to Health. Mental Health. Physical Activity and Nutrition. Parenting. Children's services.
- Transport services are a major area where [our] PHO collaborates with other small volunteer transport groups locally to get people to hospital. Providing home help is a particularly difficult undertaking in rural areas given workforce availability and cost of travel. Joint appointments and shared care help overcome these issues. Two small mental health NGOs have asked one PHO provider to take over their contracts. It is becoming difficult for some smaller NGOs to continue with ever-increasing audit and funding work required.
- Warm housing, smokefree, community development. Community Podiatry services working together collaboratively for our population.
- Working with NGOs for cardio pulmonary rehab and Sunflower Day with St John last year in our region. Regular referrals to smoking cessation services thru iwi provider.

PHOs described their most effective collaborative activities or provided details about relationships with NON-PROFIT NON-HEALTH NGO providers:

- Housing is a major issue for low income whānau and we work with several groups (e.g. refuge) to help with such whānau in need. Activities include cross referrals and joint approaches to council etc. Several schools work with one PHO provider to address young men showing anti-social behaviour. [Our] PHO provides funding for suicide prevention workshops.
- Our community nurse project in Invercargill involved working with church-groups, Māori groups, key government agencies, e.g. education, DSW, CYFS, WINZ etc.
- Providing HEADs assessments co-ordination with CYFs and return-to-work assistance with W&I.
- Rehab delivery team consists of PHO, iwi provider and Sport Gisborne. Other relationships include: dietician, pharmacist, Red Cross – all contribute teaching sessions to the programme. We commonly refer people to the iwi provider for smoking cessation support, miri miri, men's health group, Tai Chi, Kaumatua group. Pharmacist's Whānau Ora Village at recent Matatini event free had health screening and education targeted to Māori whānau. Regular contact with pharmacies throughout city to better provide care for patients, check meds dispensed, options and side effects/interactions. Ref to physio.
- Warm housing, smokefree, community development. We have developed networks with many other agencies involved with the delivery of health care. Some of these are not specifically health related, e.g. local government/bodies, CERA etc. Child Youth and Family – Gateway Assessments. All social services as part of client/patient liaison with community health workers, well-being team and outreach nursing services. Pharmacies, local dieticians, specialist nurses (i.e. eczema nurse), hearing van nurse/technician, podiatrists, WINZ worker + nurse, ACC advocate, other Māori health providers, other PHOs, Regional Public Health, city council, police, fire service, Māori Women's Welfare League, Women's Refuge, diabetes nurses, Lions Club. These and many more services have worked with us to provide specialised services/education to our clients and staff. For example: An eczema nurse specialist from the hospital runs a clinic at our service one day per month, our Tamariki Ora service books families into this clinic and runs the clinic. The RPH hearing van is based at our WellChild /immunisation service, open clinic, 1 day /week.
- We have worked with other NGO PHOs when planning education sessions and invite all concerned so that we share our resources. Worked with other organisations to develop IT tool, policies and procedures so it is transparent for all other interested parties to use.

PHOs identified these key levers or triggers that help enable more integrated models of care:

- BSMC EOI is focused on the development of new models of care.
- Care Pathways, funding support, shared planning.
- Common philosophies. Shared values. Strong relationships based on kinship, trust, integrity and long-term goals. Close to our communities. Services relevant to our needs.
- Developing a living document (health needs analysis) will identify our direction. As a very new PHO we are very aware of our responsibilities.

- Health issues/needs identified for high needs patients (i.e. Māori, Pacific Island and Deprivation 9 and 10 people) who require a multi-agency/group approach to resolve poor health cause and lifestyle determinants.
- Identified a need via surveys to our GP practices, e.g. engaging Primary care to be more alert to family violence. Work alongside outreach providers to ensure their services are used as well – enabling patients better access to the service.
- Including all stakeholders in regular quality meetings and being deliberate about improving quality together. Providing timely feedback between providers both when things go well and when they don't – creating a culture where this is welcomed. Looking for opportunities for shared learning/courses. Face-to-face and knowing who you are dealing with. Being reliable and forthcoming with what you agree to do. IT systems that talk to each other and are kept current. Teaching staff to get the most out of their PMS systems.
- Poor take up of programmes delivered through traditional general practice approaches. Offering flexible funding to other providers when we can make the bureaucracy (usually DHB or MoH) easier for smaller providers.
- We serve a high needs population, predominantly Māori and low socio-economic – multiple needs/morbidities – common values based on whānaungatanga, whakapapa and tikanga – our commitment to the Kingitanga.

PHOs suggested these factors can assist with overcoming information sharing barriers:

- Thames Hospital should install MedTech capabilities in ED and (with appropriate privacy issues addressed) access to local GP patient files.
- Trust to let others make decisions about what works best. Trust to delegate funding decisions to PHO (by DHB) – needs to happen, not quite there yet.
- The factor for successful working has to be developing and maintaining positive and trusting relationships with the collaborating NGO.
- Critical factors identified previously.

PHOs suggested these factors make a difference:

- A 'genuine' focus and commitment on an improved outcome for the patient/family. Better co-ordinated care pathways/intervention models that all agencies agree on and commit to.
- DNs and public health nurses should be taken out from a hospital-based system and integrated into primary care. Thames Hospital services (starting with ED) should be fully integrated into PHO services.
- Education and self responsibility. Strong community support structures.
- Flexible funding by DHBs. DHBs not delivering services better provided by NGOs and PHOs.
- Having co-ordinated funding streams to minimise duplication.
- Planning services around the clients with a recognition that this may mean doing things differently with existing funding.

The next phase of the project

Around 24 case study leads will be followed up around the country, with the aim of completing 8-15 profiles that will provide some insights and learnings on collaboration in primary health care.

Some of the leads are sourced from the suggestions of online survey respondents. The possible case studies they suggested included the following:

- Accreditation process of Māori providers and NGOs through the Southern PHO.
- After a referral of a stroke survivor, we provide information about rehabilitation that includes exercises, social occasions, speech language therapy and help with driving licence renewal, benefits etc.
- Asiasiga Model of Care – Family at the Core.
- Bibliotherapy Project – pilot.
- Cannons Creek specialist wound clinic.
- Cervical screening.
- Cheap Eats.
- Community-based Respiratory Rehabilitation.
- Continence clinics in GP practice.
- Development of a palliative care Nurse Practitioner role for the organisation, and development of a gerontology Nurse Practitioner role in collaboration with the DHB.
- Diabetes management.
- Diabetes patient self management programme.
- Endless choices from mental health, refugee health, maternal and child health, diabetes long-term management.
- Exploring how NGOs can gain support to work collaboratively – particularly when prevailing disadvantages are lack of space and lack of capital to address this. Where there is willingness amongst all groups concerned but frustration because space is at a premium. Where growth is entirely possible and needing to happen, but just cannot due to physical building/space confines and not enough money (even corporately) to address the issue.
- GAIHN.
- Healthier Homes.
- Home Share initiative.
- Hornby GP referral programme for hearing therapy.
- Case studies related to Strengthening Families.
- I have a model of integrated primary and secondary mental health service to those aged 0-17.
- I have many on the go but none complete. Registering Pacific services on our website.

- Lalaga. We have a programme for people of Pacific ethnicity who experience mental illness. In order to start the programme we needed two agencies to provide from their strength. We provide a location, fundraising and administrative support. The Pacific Trust Canterbury offers the Community Support Workers, the transportation and the cultural support. This collaboration has been very effective for over 2 years.
- Medication Use Reviews.
- Men's Health Week.
- Might have one, but need to contact others to know if they want us to do it! If you're short contact me at the above contact details and I should be able to help.
- MND diagnosed.
- Community Dialysis house.
- Nurse Practitioner Partnership Outreach Clinics with Te Rununga O Raukawa.
- Partnership Health Canterbury Services to Improve Access Community Work.
- PATHS projects (Providing access to health services) between MSD and DHBs.
- Primary secondary interface around MH&AS.
- Providing in-service education to practice nurses and community education on stroke prevention.
- Psychology project.
- Pulmonary Rehab in community setting.
- Reducing inequalities in cervical screening.
- Reduction in home support services for older people.
- Reefton Health.
- Referrals of prisoners at the Wellington site for hepatitis treatment at Wellington Hospital.
- Salvation Army involved us with Māori gentleman who was in dire need of support and medical assistance.
- Smoking cessation project or cooking/gardening/walking massage group.
- Multi-week, dietitian-led weight loss programme partly funded by Partnership Health that finished in May 2010.
- Strep A swabbing, services for people with diabetes.
- Supporting a family whose son/daughter is affected by a co-existing problem – mental health and drug and alcohol-related issues.
- Supporting the development of group sessions for people with CV risk of 10-15 in WBOP.
- Te Piringa o Wairarapa – proposed collaboration of providers to deliver mental health and addiction services within the Wairarapa.
- The ARC Group.
- The efficacy of introducing a clinical co-ordinator into the pathway of care for people living with Huntington's disease.
- Tracking communication in primary health care and diabetes. Video and audio of consults.

Survey questionnaire: NGOs, groups and organisations

1. ABOUT the ORGANISATION – Tick all that apply

- | | |
|---|--|
| <input type="checkbox"/> National office of a national non-profit organisation | <input type="checkbox"/> PHO |
| <input type="checkbox"/> Regional or local branch of a national non-profit organisation | <input type="checkbox"/> An umbrella group |
| <input type="checkbox"/> Regional or local non-profit, which is not part of a national body | <input type="checkbox"/> Receive funding from the Ministry of Health |
| <input type="checkbox"/> Consumer/client/patient support or advocacy group | <input type="checkbox"/> Receive funding from at least one District Health Board (DHB) |
| <input type="checkbox"/> Government agency/department | <input type="checkbox"/> Receive other (i.e. non-health) government funding |
| <input type="checkbox"/> Commercial operation/business | <input type="checkbox"/> Receive funding from non-government sources (e.g. donations, fees for service, grants, etc) |
| <input type="checkbox"/> GP/Medical Centre | <input type="checkbox"/> Any brief details? |

2. CLIENTS / CONSUMERS / PATIENTS / MEMBERS

We have a particular focus on working with or delivering services to (please tick all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Māori | <input type="checkbox"/> Older people (65 plus) | <input type="checkbox"/> Urban populations |
| <input type="checkbox"/> Pacific people | <input type="checkbox"/> Youth (12-24 years) | <input type="checkbox"/> Rural communities |
| <input type="checkbox"/> Asians | <input type="checkbox"/> Children (0-11 years) | <input type="checkbox"/> Lower decile communities |
| <input type="checkbox"/> Migrants/refugees | <input type="checkbox"/> People with chronic health issues | <input type="checkbox"/> None of the above |
| | | Other targets: |

3. COLLABORATIVE HEALTH SERVICES

Primary health care is first level contact with essential, practical health care that is universally accessible to people in the community. With this in mind, please indicate which primary health care services your organisation provides, if any.

- | | |
|--|---|
| <input type="checkbox"/> GP services | <input type="checkbox"/> Advice on nutrition and/or physical activity |
| <input type="checkbox"/> Nursing services | <input type="checkbox"/> Aged care |
| <input type="checkbox"/> Screening services | <input type="checkbox"/> Smoking cessation services |
| <input type="checkbox"/> Sexual health services | <input type="checkbox"/> Alcohol and drug dependency support |
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> In-home support services |
| <input type="checkbox"/> Counselling services | <input type="checkbox"/> Transport and accessibility supports |
| <input type="checkbox"/> Parenting support services | <input type="checkbox"/> Other health services (note details below) |
| <input type="checkbox"/> Health education or promotion | <input type="checkbox"/> We do not provide Primary Health Care services |
- Other?

4. RELATIONSHIPS WITH GPs & MEDICAL CENTRES

Thinking about your interactions with GPs and medical centres over the past two years, please tick all that apply to your organisation and your experience of primary health care services:

- We are based in a medical centre or Integrated Family Health Centre

- We regularly make referrals to GPs/medical centres
- We regularly receive referrals from GPs/medical centres
- There is an Integrated Family Health Centre established in a region we work in
- We initiated contact with GPs/medical centres to discuss ways to work together to assist the clients/consumers/patients we have in common
- A GP/medical centre initiated contact with us to discuss ways to work together to assist the clients/consumers/patients we have in common
- We have no interaction with GPs/medical centres
- We do not see any value in building relationships with GPs/medical centres
- We have worked collaboratively on at least one project/initiative/pathway with a GP/medical centre.

5. RELATIONSHIPS WITH PHOs

As at July 2011, there are 32 primary health organisations (PHOs) funded by district health boards to support the provision of essential primary health care services to enrolled PHO populations. A PHO provides services either directly or through its provider members. Thinking about your RECENT relationships with PHOs, please tick all that apply to your organisation:

- Our organisation is a provider member of a PHO
- We get invited to attend PHO Annual General Meetings
- We have attended a PHO Annual General Meeting in the past two years
- We receive updates and/or newsletters from PHO(s) informing us of their activities
- A PHO sought our input to service planning and direction-setting
- We provided input to a PHO's service planning and direction-setting
- We feel the PHO took notice of our input and respected our opinion/experience
- We initiated contact with a PHO to discuss ways to work together to assist the clients/consumers/patients we have in common
- A PHO initiated contact with us to discuss ways to work together to assist the clients/consumers/patients we have in common
- We never hear from PHOs and they have not responded to our approaches
- We don't think the PHO(s) in our area even know we exist
- We do not see any value in building relationships with PHOs
- We do not know which PHOs are active in the areas that we work in
- We have worked collaboratively on at least one project/initiative/pathway with a PHO.

6. RELATIONSHIPS WITH OTHER NON-PROFIT NGO PROVIDERS

Thinking about the past two years, and your relationships with other non-profit providers working in health, housing, education, social services and justice, please tick all that apply to your organisation and your experience or delivery of primary health care services:

- We regularly make referrals to other non-profit HEALTH providers
- We regularly make referrals to non-profit agencies working in areas such as SOCIAL SERVICES, HOUSING, JUSTICE or EDUCATION
- We regularly receive referrals via other non-profit HEALTH providers
- We regularly receive referrals via other non-profit, NON-HEALTH agencies (e.g. social services, education, justice, housing)
- We initiated contact with other non-profit NGO providers to discuss ways to work together to assist the clients/consumers/patients we have in common
- Another non-profit NGO provider initiated contact with us to discuss ways to work together to assist the clients/consumers/patients we have in common
- We have become part of a network of agencies established to deliver WHĀNAU ORA services

- We do not see any value in building relationships with other non-profit NGO providers
- We have worked collaboratively on at least one project/initiative/pathway with another non-profit HEALTH provider
- We have worked collaboratively on at least one project/initiative/pathway with another non-profit NON-HEALTH agency (e.g. social services, education, justice, housing).

7. OTHER RELATIONSHIPS

Still thinking about your organisation's experiences with primary health care, what other organisations do you have relationships with and how do these benefit your clients/consumers/patients?

(These relationships might be with allied health providers such as pharmacies, nutritionists, massage therapists or physiotherapists; or with commercial businesses or government agencies, etc.)

8. WHAT'S CHANGED?

In the past two years, have you experienced or observed primary health care services that changed in any of the following ways?

- These primary health care providers STARTED working collaboratively:
- The way this service was delivered CHANGED to complement the primary health care services offered by others:
- This NEW SERVICE was created to complement what other primary health providers offer:
- Duplication was identified, so this activity STOPPED:
- The way information is COLLECTED and SHARED was IMPROVED by:
- This BARRIER to collaboration was identified:
- This BARRIER to collaboration was overcome:
- This new source of FUNDING helped to increase capacity/service delivery:

9. WHAT MAKES A REAL DIFFERENCE?

Based on your experiences of primary health care and/or working collaboratively, please answer these questions as specifically as possible:

- What key levers or triggers have you (or others) used to enable PHOs, NGOs and other primary health care providers to develop models of care that are significantly more integrated from a patient/client/consumer's perspective?
- What future changes would truly add value to improve wellness and early intervention, and deliver effective service integration across the PHO-NGO interface?

10. CONTACT DETAILS

Please provide your contact details and indicate if you are involved in a collaborative PRIMARY HEALTH CARE initiative that might make a useful case study.

Survey questionnaire: PHOs

1. YOUR PHO

As at July 2011, there are 32 primary health organisations (PHOs) funded by district health boards to support the provision of essential primary health care services to enrolled PHO populations. With so many changes and amalgamations over the past year or so, it has been hard to keep track of which is which. Can you please tell us which PHO you are and where you operate?

PHO name:

Region covered:

District Health Boards (DHB) in our coverage area:

Enrolled PHO population:

Number of provider members:

Number of FTE staff employed in our PHO:

Number of Integrated Family Health Centres established in our region (if any):

2. PHO ACTIVITY

Thinking about how your PHO engages with your community, please tick all that apply:

- We have non-profit health NGOs registered as provider members of our PHO
- We invite other non-profit NGOs/community groups to attend our PHO Annual General Meetings
- Other non-profit NGOs/community groups have attended a PHO Annual General Meeting in the past two years
- We send non-profit NGOs/community groups updates and/or newsletters informing them of our activities
- We sought input to service planning and direction-setting from non-profit NGOs (which aren't provider members)
- Non-profit NGOs (which aren't provider members) provided input to our PHO's service planning and direction-setting
- We gained real value from the input provided by a non-profit NGO (which isn't a provider member)
- We don't really know which non-profit health NGOs are operating in our area

Please make a comment about the quality or value of your engagement with your community so far (e.g. what could non-profits and community groups do to make it easier for your PHO to engage and involve them?)

3. COLLABORATIVE SERVICES

Many non-profit NGOs are involved in delivering primary health care (i.e. first level contact with essential, practical health care that is universally accessible to people in the community).

Please indicate which primary health care services your PHO has COLLABORATED with non-profit NGOs in delivering – if any. (Please tick all that apply):

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Health education or promotion |
| <input type="checkbox"/> GP services | <input type="checkbox"/> Advice on nutrition and/or physical activity |
| <input type="checkbox"/> Nursing services | <input type="checkbox"/> Aged care |
| <input type="checkbox"/> Screening services | <input type="checkbox"/> Smoking cessation services |
| <input type="checkbox"/> Sexual health services | <input type="checkbox"/> Alcohol and drug dependency support |
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> In-home support services |
| <input type="checkbox"/> Counselling services | <input type="checkbox"/> Transport and accessibility supports |
| <input type="checkbox"/> Parenting support services | <input type="checkbox"/> Other health services (note details in box below) |

4. RELATIONSHIPS WITH NON-PROFIT NGO HEALTH PROVIDERS

Thinking about the past two years, and your relationships with other non-profit HEALTH providers, please tick all that apply to your PHO and your delivery of primary health care services:

- We regularly engage with other non-profit HEALTH providers (which are not provider members)
- We initiated contact with at least one non-profit NGO HEALTH provider to discuss ways to work together to assist the clients/consumers/patients we have in common
- A non-profit NGO HEALTH provider initiated contact with us to discuss ways to work together to assist the clients/consumers/patients we have in common
- We have engaged with a network of agencies established to deliver WHĀNAU ORA services
- We find it difficult to know what NGO health providers exist in our area and what complementary services they offer
- We do not see any value in building relationships with other non-profit NGO HEALTH providers
- We have worked collaboratively on at least one project/initiative/pathway with another non-profit HEALTH provider

5. RELATIONSHIPS WITH OTHER NON-PROFIT NON-HEALTH NGO PROVIDERS

Thinking about the past two years, and your relationships with other non-profit providers working in HOUSING, EDUCATION, SOCIAL SERVICES and JUSTICE, please tick all that apply to your PHO and your delivery of primary health care services:

- We regularly engage with non-profit NGOs working in SOCIAL SERVICES
- We regularly engage with non-profit NGOs working in HOUSING
- We regularly engage with non-profit NGOs working in JUSTICE
- We regularly engage with non-profit NGOs working in EDUCATION
- We initiated contact with at least one non-profit NON-HEALTH NGO provider (e.g. social services, education, justice, housing) to discuss ways to work together to assist the clients/consumers/patients we have in common
- A non-profit NON-HEALTH NGO provider initiated contact with us to discuss ways to work together to assist the clients/consumers/patients we have in common
- We do not see any value in building relationships with non-profit NON-HEALTH NGO providers
- We don't know how to tap into the appropriate NGO networks to find out how they could assist our common clients/patients/consumers
- We have worked collaboratively on at least one project/initiative/pathway with a non-profit NON-HEALTH agency (e.g. social services, education, justice, housing)

6. KEY LEVERS and TRIGGERS

Based on your experiences of working collaboratively in primary health care, please answer this question as specifically as possible:

What key levers or triggers have you (or others) used to enable PHOs, NGOs and other primary health care providers to develop models of care that are significantly more integrated from a patient/client/consumer's perspective?

7. WHAT'S CHANGED?

In the past two years, have your primary health care services changed in any of the following ways?

- We STARTED working collaboratively with this primary health NGO provider:
- We STARTED working collaboratively with this non-profit, non-health agency:
- We CHANGED the way this primary health care service is delivered to complement the services offered by others:

Original project scope

As envisaged at start of project on 1 July 2011

Title: How NGOs contribute to improving Primary Health Care in NZ

Examples of how non-profit NGOs help improve primary health sector outcomes through innovative, integrated models of care – and what gets in the way of this.

Project overview

There is a vast array of reports, strategies, plans and discussion documents about primary health care for government policy advisors to pore over and analyse. The added value that the Health and Disability NGO Working Group can bring to this challenge is the real world experience of its members and wider health and disability NGO networks.

Anecdotal evidence suggests there are barriers to more integrated primary health care models, yet some NGOs and other primary care providers manage to make it work. This research project will profile 8-15 examples of NGOs working collaboratively in different health fields and locations. It will describe their experiences working with other primary health care providers (such as PHOs) to deliver integrated primary health care services; and it will attempt to analyse what makes a difference. The focus will be on identifying what works, what factors play a key role in success, and what gets in the way.

The NGO/PHO stories will be supplemented with findings from an online survey of the wider health and disability NGO sector – seeking quantitative information about their services, their challenges and their opportunities for providing more effective, integrated primary health care services.

This is the first phase of the NGO Working Group's Primary Health Care project. The next phase will depend on the analysis of the barriers and success factors, and whether these relate to policy issues and funding models, or systemic ways of operating and relationship building. In the meantime, the NGO profiles will provide opportunities to raise awareness of the important contribution NGOs make to health outcomes for New Zealanders.

Core theme of proposed report (key message)

The NGO sector is a major provider of public and personal primary health care in New Zealand. Its expertise and community reach ideally position it to assist the government to achieve better health outcomes for New Zealanders. Greater co-ordination between ALL providers will deliver integrated primary health services that improve effectiveness and efficiency across health and disability services in primary health. The examples identified in this report illustrate how integrated health services involving NGOs can help lift taxpayers' return on investment in health – reducing the use of secondary and tertiary health services and encouraging personal responsibility for wellness.

Primary Audience

- Ministry of Health primary health care policy team

Other stakeholders the report may be useful to

- Health Minister/Associate Minister and health spokespeople from other parties
- National Health Board
- NGOs working in Primary Health Care – including:
 - Pacific providers
 - Māori providers
 - mental health
 - consumer providers, etc
- PHOs
- Health Quality & Safety Commission, Health & Disability Commissioner
- Whānau Ora providers
- DHBs

Objectives/Purpose

The research findings will aim to:

- influence government policy and funding models for Primary Health Care services (especially Ministry of Health and DHBs)
- advise government Ministers and other party spokespeople on the views of health and disability sector NGOs about Primary Health Care
- raise awareness about the range of Primary Health Care services non-profit NGOs can provide (especially among PHOs)
- help NGOs identify opportunities to contribute more effectively to the provision of Primary Health Care in New Zealand via integrated service delivery models.

Content of paper

The profiles in the report will cover a range of primary health services delivered by NGOs in conjunction with other primary health care providers.

Possible examples may include some of the following:

- WellChild checks
- Parenting and behaviour support services
- Māori health services (probably a Whānau Ora provider/example)
- Pacific health services (that draw on the strengths and opportunities within Pacific communities in NZ)
- Community health services (e.g. Pomare, Newtown or Nelson's Victory Village)
- Mental health service
- Consumer providers
- Health education
- Sexual health example
- Counselling services

- Diabetes service
- Alcohol and drug dependency (including methadone treatment) services
- Integrated family health centre (e.g. Tararua Health in Dannevirke)
- Nutrition and physical activity
- Screening services
- Smoking cessation supports
- Transport and accessibility supports
- Aged care
- In-home support services
- Cardiovascular health example

The profiles will:

- identify examples of successful service co-ordination and particular strategies that NGOs and PHOs consider productive for advancing integration and new models of care
- describe the issues and barriers for NGOs arising from attempts to work with PHOs to provide better integrated services via multiple points of entry
- provide an NGO perspective on opportunities for integration through innovative models of co-ordination and co-operation between NGOs and the broader primary health sector (e.g. virtual integrated family health centres in partnership with GPs, public health services and other ancillary health and social service providers, alternative pathways to care)
- possibly include one or two examples where the barriers have been insurmountable so far (i.e. non-profit NGOs are shut out.)

A consistent interview structure will be followed, but with a flexible approach allowing for appropriate delivery and questioning most suitable to the examples being profiled.

Lines of questioning are likely to include:

- What does the service deliver?
- What providers are involved in the delivery?
- How is the service integrated and connected to other providers?
- How are commercially-focused PHOs and/or community-based PHOs involved – were they the drivers of the integrated approach?
- Who led the initiative to its current delivery model?
- How long did the process take?
- Who benefits most from the collaboration? How does the patient/consumer benefit? How is their experience different?
- What population groups does the service work with?
- How have the services reduced inequalities or improved access for disadvantaged groups?
- How do non-profit NGOs help target services to address issues of long-term disadvantage and complexity for marginalised population groups?

- How is it funded?
- How does the funding model affect integrated models of care?
- How were costs able to be reduced?
- What impact does location and community connections have on the service?
- What role (if any) does integration with other non-health agencies play? (e.g. welfare, education, police, etc.)
- Is this example unique to a region/population or is it a local response to a national issue?
- What lessons can the wider health and disability sector learn from the approaches being used?
- How could this approach be replicated elsewhere or adapted for use more widely? What learnings could others take from the example?
- Where integration does occur, what factors help it to happen, and what gets in the way?
- What were the key factors that help them succeed?
- What role has training, upskilling and/or workforce development played in supporting the collaborative approach? What skill or knowledge gaps have had to be filled?
- What roles do IT systems and technology play in supporting or preventing service integration?
- If there is a central access point for both practitioners and clients/patients, how does it help to facilitate a smooth journey for the client/patient and enable easier collaboration for health practitioners?
- How do the different providers connect into a clear and transparent care (treatment and support) pathway with well delineated responsibilities for engagement of key personnel at each stage of the pathway?
- How is demographic information shared to enable all parties to understand the nature and extent of the needs?
- What performance measurement processes are in place to inform and/or improve quality of care?
- How are referrals supported and encouraged and what systems are in place to provide important feedback to the referrer? What specifically do nurses, doctors etc do to support referrals?
- What **specific** levers or triggers helped make a difference? What is done differently?
- What does an 'ideal' primary health care team look like in this example? Who is involved?

Selection criteria for case studies

Not all primary health areas can be explored within the resource constraints of this phase of the project. An important focus needs to be on choosing appropriate case studies with real potential to **provide specific insights** that will facilitate greater collaboration between providers in the future.

Therefore case studies will probably feature:

- at least one non-profit NGO and a PHO working together (views from a range of participants will be obtained to ensure different perspectives are illustrated)

- formal and informal arrangements between PHOs and NGOs (e.g. co-location, the PHO paying non-profit NGOs for services, etc)
- non-profit NGOs involved early in planning processes (e.g. at the set up stage)
- true collaboration (e.g. non-profit NGOs as members of advisory groups, an inclusive process, etc)
- innovative approaches to reaching marginalised or high risk communities (e.g. youth and sexual health)
- established services that have had time to measure achievements and reflect on what specific factors make a difference
- comprehensive referral processes and solid systems to provide feedback to referrers
- contemporary examples established since many PHOs have amalgamated (e.g. Southern PHO)
- examples that allow us to identify real learnings and don't just provide a bunch of 'nice stories'.

Where possible, examples will be chosen that feature a general health service working with specific population groups (e.g. a mental health service focused on Pacific communities).

Project success factors

A range of examples will be needed and the report will have to go beyond just describing what they did. It will need to focus on the **key factors that made a difference** and the barriers that got in the way.

The research intends to build upon existing bodies of work and information from known networks and informed sources regarding best practice collaborative health initiatives. But it also needs to bring something new to the table – adding value via the NGO Working Group members' own experiences and wider networks with the health and disability NGO sector.

NGO working group members, NGO health and disability providers and key umbrella groups will be vital sources of real-life examples and information on issues and solutions if innovative ideas are to be identified and analysed. Possible case studies may also be identified through forthcoming national events such as Victory Village Forum (Nelson, 27-29 July), NZ Home Health Assn Conference (Wellington, 3-5 August) and Public Health Assn Conference (Christchurch, 31 Aug-2 Sept).

Working Group members can play a key role in making introductions and in some cases conducting an interview or visit in their region to gain greater insights than can be obtained by phone or e-mail, as there are unlikely to be project resources available for contractor's travel/accommodation costs.

Background

Non-government organisations (NGOs) receive significant funding (in the order of \$2 billion-\$4 billion per year [approximately 25% of overall non-departmental health operating budget of \$12.8 billion]) from both the Ministry of Health and district health boards. Many are non-profit, and along with providing services to consumers they are a valuable contact at community level.

Primary health care covers a broad range of health and preventative services, including health education, counselling, disease prevention and screening.

Non-government organisations have a long, well-established record of contribution to New Zealand's health and disability service delivery. Health and disability NGOs include a wide range of organisations that provide flexible, responsive and innovative frontline service delivery. Diverse services are offered in primary care, mental health, personal health, and disability support services, and include kaupapa services, such as Māori and Pacific providers. Many of these providers/groups/organisations provide valuable input into the well-being of the community⁵.

Health purchasing changes in the early 1990s aimed at improving competition and choice in the health and disability sectors led to a proliferation of providers. The NGO sector flourished in response to the complex needs of key population groups in the community. The sector is now at a cross roads as government reforms aim to deliver care that will add value and efficiency at a time of burgeoning health and disability spend.

Many aspects of primary healthcare function with little integration, co-ordination or collaboration with the NGO health and disability sector. This creates gaps in care, duplication and confusion for consumers and community alike. The NGO/MoH Working Group suggests that the largest impact on health outcomes for individuals, whānau and community will arise from better integration and co-ordination of services.

There is a need to define the current scope of NGO contributions to the primary health sector and for renewed models of co-ordination and co-operation. Key to its success is the role of primary health in reducing demand for tertiary services. There is a need to improve the return on investment of taxpayers' dollars and provide measurable health gains to disadvantaged groups by reconfiguring the shape and delivery of services in the primary sector.

Ongoing issues of equity and access to primary health services, as well as the appropriate mode of delivery to Māori as tangata whenua and Pacific groups have yet to be realised. The NGO/MoH working group supports a primary health care philosophy that is centred on a person/whānau approach. The delivery of primary health care needs to be responsive to individual and community need, flexible, adaptable and appropriate. The NGO health and disability sector providers have a breadth of experience in providing this and a willingness to work in collaboration with others in delivery of services.

Improved integration will require a greater acknowledgement of the wide range of practitioners/professionals and funders who contribute to Primary Health Care and a commitment to engage with the NGO sector. Building of relationships, collective understanding of each other's roles, and **trust**, will be vital to the development and success of any future Primary Health Care models.

⁵ Source: Ministry of Health website – accessed 10 May 2011

Likely key information sources

Background information and context will be drawn from:

- *Better, Sooner, More Convenient Primary Health Care*
– the Government's initiative to deliver a more personalised primary health care system that provides services closer to home and makes Kiwis healthier. A package of services is proposed to make significant improvements. This includes multiple Integrated Family Health Centres, nurses acting as case managers for patients with chronic conditions, providing a wider range of care and support for patients and shifting some secondary care services to primary care.
For information relating to this initiative go to:
<http://www.moh.govt.nz/moh.nsf/indexmh/phcs-bsmc#backtotop> and see 2011 profiles at <http://www.moh.govt.nz/moh.nsf/indexmh/better-sooner-more-convenient-health-care>
- 9 successful proposals from PHOs for the *Better, Sooner, More Convenient Primary Health Care* initiative.
See <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-bsmc-proposals>
- *The Primary Health Care Strategy*, Ministry of Health, February 2001.
Download this document at:
<http://www.moh.govt.nz/moh.nsf/0/7bafad2531e04d92cc2569e600013d04?OpenDocument>
- *The NGO Sector Role: A Key Contributor to New Zealand's Health and Disability Services – 2010*
Recent changes in the political and economic environments of most western democracies indicate a further change in the role and participation of NGOs in health and disability sector service provision may be imminent. Those changes are explored in this paper, which quantifies the current contribution of NGOs and includes examples that show when NGOs collaborate, they are key drivers of innovation. That capacity to innovate will play a significant part in the future sustainability of health and disability services in this country.
Available at: <http://www.ngo.health.govt.nz/moh.nsf/indexcm/ngo-resources#1>
- *Barriers and Opportunities for Innovation and Collaboration in the Health and Disability NGO Sector – 2007*
This document summarises a number of issues raised by NGOs about the barriers to and opportunities for innovation and collaboration within the health and disability NGO sector. Available at: <http://www.ngo.health.govt.nz/moh.nsf/indexcm/ngo-resources#1>
- *Non Government Organisations (NGOs) and the Primary Health Care Strategy – Developing relationships with Primary Health Organisations from an NGO perspective – 2005*
This study explores the experiences, and identifies the key issues, of eight NGOs as they sought to develop relationships with primary health organisations (PHOs), and establish their fit within the new primary health care structure. The study also draws on statements reflected in the NGO – MOH survey of relationships with DHBs and the Ministry of Health.
The full report is at: <http://www.ngo.health.govt.nz/moh.nsf/indexcm/ngo-resources#1>

- *The New Zealand Health Strategy*, Ministry of Health, December 2000.
Download this document at: <http://www.moh.govt.nz/nzhs.html>
- *Trends in Service Design & New Models of Care* literature review from the National Health Board, Aug 2010.
Available from: <http://www.hiirc.org.nz/page/21269/trends-in-service-design-and-new-models-of/?section=9097&tab=27>
- *He Ritenga Whakaaro: Māori experiences of health services*, Mauri Ora Associates, January 2009.
Download this report at: <http://www.mauriora.co.nz/file/He-Ritenga-Whakaaro.pdf>
- *Whānau Ora – a whānau centred approach to Māori well-being*, New Zealand Public Service Association (PSA), November 2009.
Download this document at:
http://www.psa.org.nz/Libraries/PSA_Documents/PSA_submission_Whānau_Ora_Nov2009.sflb.ashx
- *He Korowai Oranga: Māori Health Strategy*, Ministry of Health, November 2002.
Download this document at: <http://www.moh.govt.nz/mhs.html>
- *Ala Mo'ui – Pathways to Pacific Health and Well-being 2010-2014*, Ministry of Health, March 2010.
Download this document at: <http://www.moh.govt.nz/moh.nsf/indexmh/ala-moui-pathways-to-pacific-health-well-being2010-2014>

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Above [Wordle](#) graphic created from survey responses about 'Relationships with PHOs'.

Back cover [Wordle](#) graphic created from survey responses about 'Relationships with NGOs'.

