Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Annual Report

1 JULY 2016 – 30 JUNE 2017

Healthy People | Healthy Workplace | Healthy Community

Our Region

RICHMOND/WAKEFIELD PRACTICES

Florence Medical Centre
Richmond Health Centre
Tasman Medical Centre
Washbourn Medical Centre
Wakefield Health Centre

NELSON PRACTICES

Dr Jolly's Practice
Dr Liz Scott
Harley Street Medical
Harrison Moore Medical
Medical and Injury Centre
Nelson City Medical Centre
Nelson East Family Medical Centre
Nelson Family Medicine
Rata Medical
St Luke's Health Centre
Stoke Medical Centre
Tahunanui Medical Centre
Collingwood Health
Tima Health

MAPUA/MOTUEKA/ GOLDEN BAY PRACTICES

Mapua Health Centre
The Doctors Motueka
Greenwood Health
Golden Bay Community Health

MARLBOROUGH

Renwick Medical Centre

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Welcome to Nelson Bays Primary Health

Nelson Bays Primary Health operates as a Charitable Trust.

The role of Nelson Bays Primary Health is to lead and coordinate primary health care in Nelson Bays, to strive for health equity and to improve health outcomes for all people. These services include not only first line services to restore people's health when unwell, but in conjunction with the local community and other health care providers, also targeted programmes which aim to improve and maintain good health throughout the region.

The Nelson Bays Primary Health Board is made up of community, Iwi/Māori and provider representation from the Nelson and Tasman region. The role of the Board is to provide leadership, set the organisation's strategic direction and vision, set policies, organisational performance measures and appoint, delegate authority to and monitor the Chief Executive. The Board acts within the boundaries of its own Trust Deed, as well as other relevant legislation and regulations.

"we strive for health equity and to improve health outcomes for all people..."

General Practices

The following chart lists the 24 General Practices who were contracted to Nelson Bays Primary Health within 2016/17 financial year

NELSON
Dr Janice Jolly's Practice
Dr Liz Scott's Practice
Harley Street Medical
Harrison Moore Medical
Medical and Injury Centre
Nelson City Medical Centre
Nelson East Family Medical Centre
Nelson Family Medicine
Rata Medical Centre
St Luke's Health Centre
Stoke Medical Centre
Tahunanui Medical Centre
Tima Health
Collingwood Health

MAPUA, MOTUEKA, GOLDEN BAY
Mapua Health Centre
The Doctors Motueka
Greenwood Health
Golden Bay Community Health

RICHMOND, WAKEFIELD
Florence Medical Centre
Richmond Health Centre
Tasman Medical Centre
Wakefield Health Centre
Washbourn Medical Centre

MARLBOROUGH
Renwick Medical Centre

COST OF ACCESSING PRIMARY CARE SERVICES

A full list of General Practice fees is on the Nelson Bays Primary Health website **http://nbph.org.nz/gp-fees-table**

There are two General Practices in the Nelson Bays region that are Very Low Cost Access General Practices and one General Practice with Access (low cost for CSC holders).

He Mihi

He hōnore, he korōria ki te Atua
He maunga rongo ki te mata o te whenua
He whakaaro pai ki ngā tāngata katoa

kia ā tātou tini mate, kua riro atu ki tua o te arai, ki te okiokinga i o tātou tūpuna haere, haere, haere. Kapiti hono tātai hono te hunga wairua ki a rātou. Kapiti hono tātai hono tātou te hunga ora tēnā tātou.

E ngā mana, e ngā reo, e ngā karangatanga maha tēnā koutou, tēnā koutou, tēnā koutou katoa.
E mihi kau ana ki ngā mana whenua o tēnei rohe ki Te tiawa, Ngāti Tama, Ngāti Kuia, Ngāti Koata, Ngāti Rārua, Ngāti Toarangatira.

Ko te kaupapa Nelson Bays Primary Health, Pūrongo-a-Tau 2017 i whakaatu ā mātou mahi o te tau. Nā reira e mihi atu ana ki a rātou katoa mō ngā mahi kua mahia e rātou ki te tutuki o mātou tumanako kia piki te ora, kia piki te kaha ki roto ki tēnā, ki tēnā o tātou katoa. Heoi anō e hara i te toa takitahi engari he toa takitini kē. Nā reira tēnā koutou, tēnā koutou, tēnā tātou katoa.

ENGLISH VERSION

Honour and glory to God
Peace on earth
Goodwill to all people

We acknowledge and farewell all those who have passed on beyond the veil of darkness to the resting place of our ancestors. The lines are joined the deceased to the deceased. The lines are joined the living to the living.

To the authority and the voices, of all people within the communities greetings to you all.
We acknowledge the Mana Whenua iwi,
Te Ātiawa, Ngāti Tama, Ngāti Kuia, Ngāti Koata, Ngāti Rārua, and Ngāti Toarangatira
in the Nelson Tasman region.

This is the annual report of Nelson Bays Primary Health 2016-17, presenting our work accomplished over the last 12 months. We acknowledge all of the work undertaken by everyone in the primary health sector that helped to achieve the health outcomes. Success is not the work of one, but the work of many.

About Nelson Bays Primary Health

Our vision

Healthy people...

Healthy workforce...

Healthy community.

Kia piki te ora o ngā tāngata katoa

Our values

Integrity
Manaakitanga

Excellence
Rangatiratanga

Respect
Whanaungatanga

Innovation
Mātauranga

Inclusion
Wairuatanga

Our goals

Improved quality, safety and experience

Best value for money

Improved health and equity

Whakapiki ake nga take haumaru, kounga hauora hoki i waenganui i te hāpori

Our mission

Everyone working in unison
to achieve the vision

Kia whakakotahi te hoe o te waka

Our guiding principle

What is the most important thing in the world?

It is the people, it is the people, it is the people

He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

Nelson Bays Primary Health

Strategic Plan 2016-2021

MISSION **Everyone working in unison to achieve the vision**
Kia whakakotahi te hoe o te waka

VISION **healthy people... healthy workforce... healthy community!**

VALUES

Integrity Manaakitanga	Excellence Rangatiratanga	Respect Whanaungatanga	Innovation Mātauranga	Inclusion Wairuatanga

STRATEGIES

PROTECTION HEALTHY PEOPLE	PARTICIPATION HEALTHY WORKFORCE	PARTNERSHIP HEALTHY COMMUNITY
A. Support healthy living in the home	A. Implement best practice governance, cultural competency and management	A. Work in partnership with our key communities to ensure an inclusive whole-of-system approach
B. Ensure health information is accessible and understandable	B. Work in partnerships to avoid duplication of services	B. Address inequalities and gaps in services, particularly for our most vulnerable and high needs populations
C. Promote and support strong clinical governance and leadership	C. Enable our workforce to operate at the top of their scope	C. Achieve all relevant health targets and indicators
D. Ensure service planning and include consumer and community involvement	D. Ensure sustainable and high quality service provision across the region	D. Support evidenced-based models of care that have proven health outcomes
E. Ensure legal obligations are adhered to	E. Focus on prevention, early detection and self-management to reduce disease progression	

ACHIEVING TRIPLE AIM OUTCOMES OF

IMPROVED QUALITY SAFETY AND EXPERIENCE	BEST VALUE FOR MONEY	IMPROVED HEALTH AND EQUITY

OUR GUIDING PRINCIPLE **What is the most important thing in the world?**
It is the people, it is the people, it is the people...
He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

UNDERPINNING DOCUMENTS: New Zealand Health Strategy 2015 - The Ottawa Charter 1986 - Te Tiriti O Waitangi 1840

Nelson Bays Primary Health

Māori Health Strategic Plan 2016-2021

VISION/ARONUI **To increase access, achieve equity and improve health outcomes for whānau, hapū and iwi Māori living in the Nelson Tasman rohe**

VALUES

Integrity Manaakitanga	Excellence Rangatiratanga	Respect Whanaungatanga	Innovation Mātauranga	Inclusion Wairuatanga

STRATEGIES

WHANAUNGATANGA CONNECTIONS PARTNERSHIPS

A. All services and initiatives whānau-focused, empowering iwi Māori to achieve rangatiratanga focus

B. Strong connections between NBPH and iwi Māori to support them to maintain healthy lifestyles exist

C. Strengthened relationships with marae as a key point of connection with iwi

D. Strengthened relationships with Te Piki Oranga and other Māori community health providers exist

E. Strategies that preserve, maintain, develop and utilise mātauranga Māori to enable whānau ora exist

WHAI ORANGA PREVENTION QUALITY PROTECTION

A. Improved Māori health outcomes through emphasis on prevention, early detection, maintenance and self-management

B. All NBPH staff are appropriately supported and trained to support iwi Māori

C. Pukengatanga - High quality service provision across the rohe for the benefit of iwi Māori and colleagues exist

D. Cultural competencies and referral pathways programmes are implemented to improve access and engagement with Māori patients and whānau

E. The diversity of the workforce and representation of Māori in Primary Care exist

MATAURANGA LEARNING PARTICIPATING

A. Māori whānau are engaged in lifestyle changes, enabling healthier futures

B. Population health promotion initiatives that address healthy lifestyle choices and health literacy in marae and other Māori environments exist

C. Social determinates of health to be foremost in future national policy and funding decisions through NBPH influence on central government

D. All NBPH service planning include a Māori health perspective

ACHIEVING TRIPLE AIM OUTCOMES OF

ACHIEVING RANGATIRATANGA	BUILDING ON MAORI HEALTH GAINS	ACHIEVING EQUITY

OUR GUIDING PRINCIPLE **People are our most valuable asset, they are our physical wealth and a reflection of our physical and spiritual health. We must empower, develop, value and retain them.**

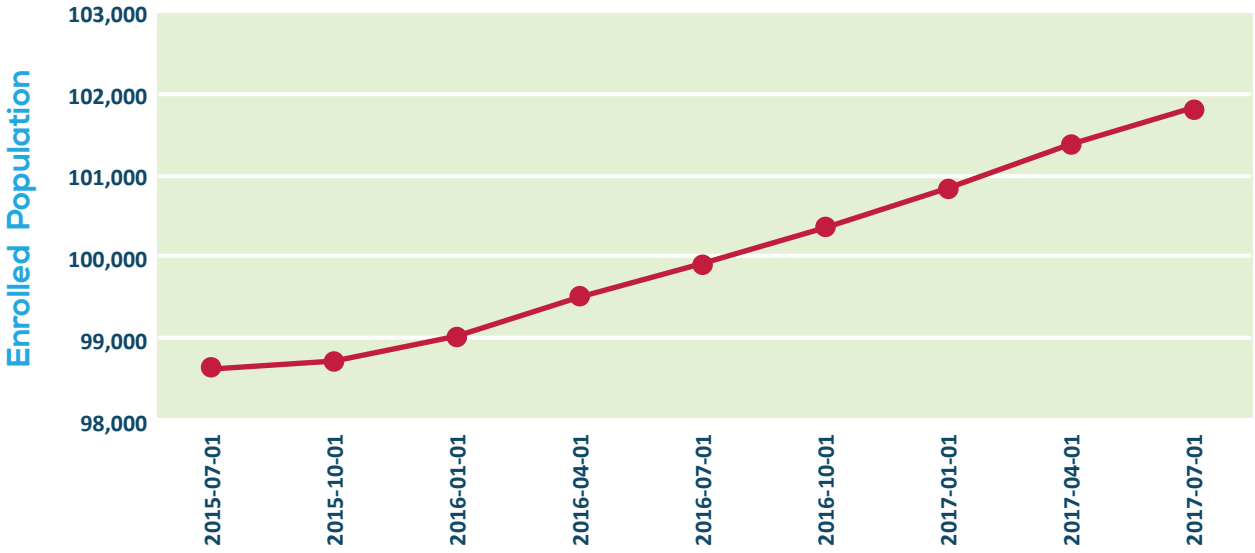
He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

Nelson Bays

Enrolled Population

NELSON BAYS PRIMARY HEALTH POPULATION

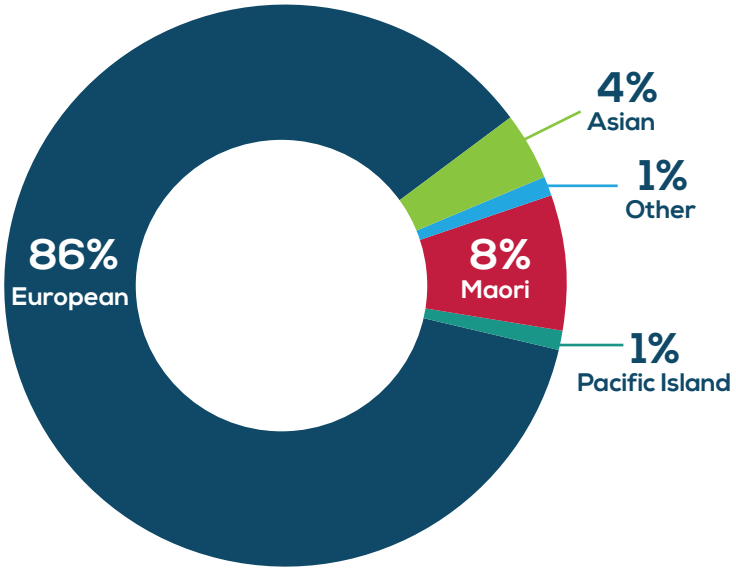
QUARTER	TOTAL POPULATION	% CHANGE
2017-07-01	101,989	+0.5%
2017-04-01	101,507	+0.6%
2017-01-01	100,940	+0.5%
2016-10-01	100,420	+0.5%
2016-07-01	99,954	+0.4%
2016-04-01	99,517	+0.5%
2016-01-01	99,007	+0.3%
2015-10-01	98,680	+0.1%
2015-07-01	98,580	–



At the end of June 2017 101,989 people were enrolled with Nelson Bays Primary Health

ETHNICITY

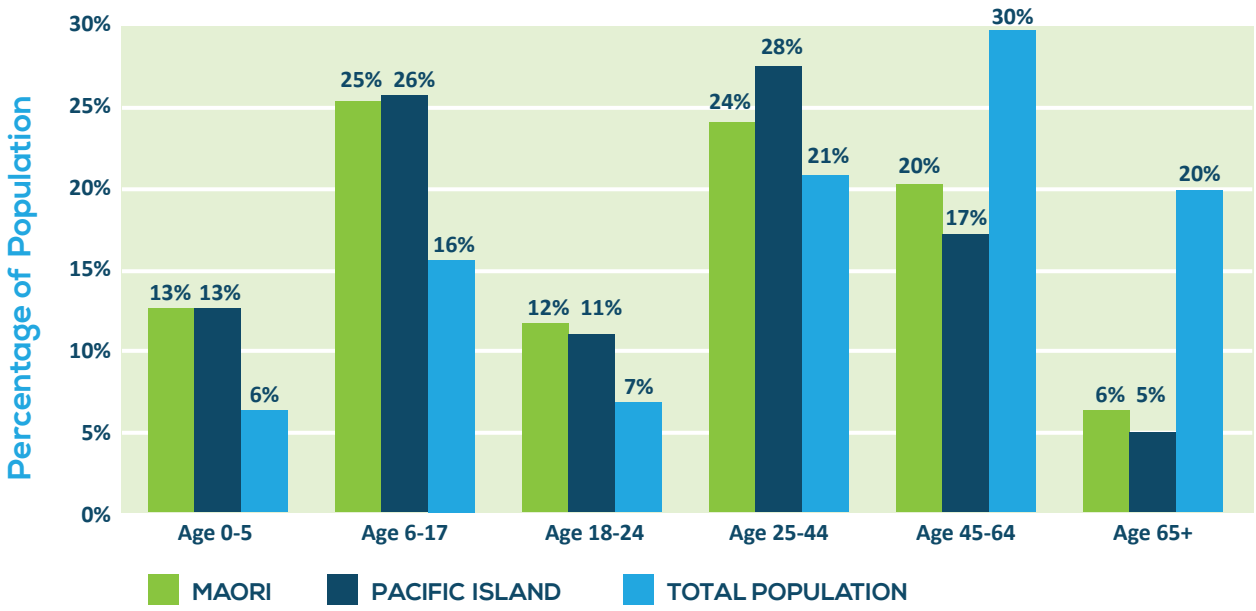
ETHNICITY	NUMBER	PERCENTAGE
Māori	8,472	8%
Pacific Island	1,220	1%
European	87,442	86%
Asian	3,576	4%
Other	1279	1%
TOTAL	**101,989**	**100%**



Nelson Bays

Enrolled Population

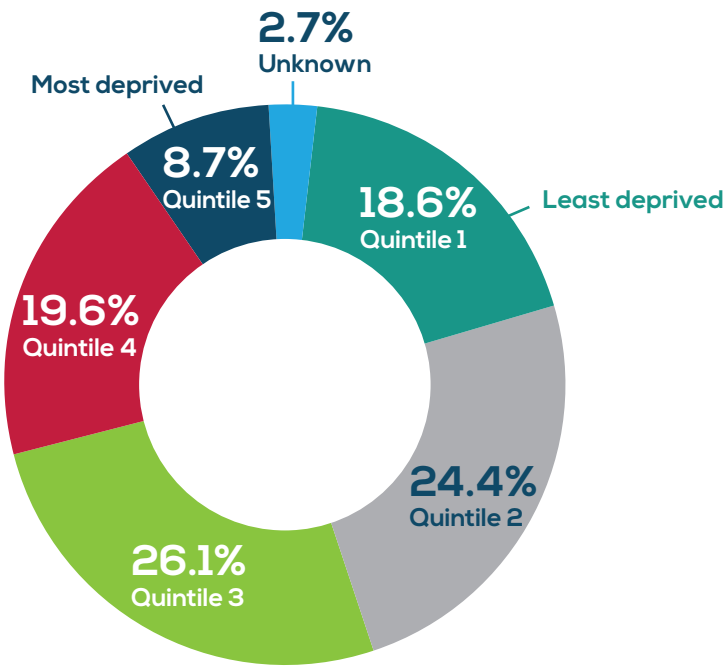
AGE GROUP PERCENTAGE OF POPULATION



AGE	MAORI	PERCENTAGE	PACIFIC ISLAND	PERCENTAGE	TOTAL POPULATION	PERCENTAGE
00-05	1066	13%	164	13%	6,569	6%
06-17	2144	25%	315	26%	15,975	16%
18-24	986	12%	134	11%	6,923	7%
25-44	2053	24%	337	28%	21,252	21%
45-64	1708	20%	212	17%	30,529	30%
65+	515	6%	60	5%	20,741	20%
TOTAL	**8,472**	**100%**	**1,222**	**100%**	**101,989**	**100%**

DEPRIVATION BY QUINTILE

QUINTILE	NUMBER	PERCENTAGE
Unknown	2,726	2.7%
1 (Least deprived)	18,763	18.6%
2	24,645	24.4%
3	26,343	26.1%
4	19,767	19.6%
5 (Most deprived)	8,745	8.7%
TOTAL	**100,989**	**100.0%**



Chairman's Report

> *... executive structures continue to work well and all staff continue to showcase innovation and performance for the benefit of both the PHO and our community.*

It is with pleasure that, on behalf of our Board, I present Nelson Bays Primary Health's Annual Report and Financial Statements for the year ended 30 June 2017.

This year's Annual Report showcases the services that your Primary Health Organisation (PHO) provides to the community, and demonstrates the ways in which we improve the lives of all those in our community.

This past year has been one where we have consolidated and further enhanced the performance of the PHO. Key examples of this include Golden Bay Community Health:

BOARD MEMBERS 2016-2017

John Hunter
CHAIRMAN

Philip Chapman
DEPUTY CHAIR, JULY - OCT 16
COMMUNITY REPRESENTATIVE

Lisa Lawrence
IWI/MĀORI REPRESENTATIVE

Pat Curry
DEPUTY CHAIR, OCT 16 - JUNE 17
COMMUNITY REPRESENTATIVE

The Golden Bay Community Health facility has made considerable progress under the guidance of our new managers:

- Community trust and support is increasing
- New systems and processes are being implemented to bridge the financial gap between the cost of this facility and the provision of care required for the community. Such changes include the introduction of a new model of care within the facility
- Waiting times for General Practice (GP) appointments has significantly improved and utilisation of beds within the facility has increased
- A revised funding model has been introduced by Nelson Marlborough Health which has enabled current and ongoing financial viability of our facility

Our PHO has two joint Ventures:

- The Medical and Injury Centre Ltd, which is jointly owned by the Nelson Bays General Practice Ltd and the PHO. In addition to being a GP, this centre provides after hours GP services for the Nelson region and increasingly acts as a triage facility, reducing the demand on the hospital Emergency Department
- Health Systems Solutions Ltd, which is a collaboration between most of the South Island PHO's to deliver IT software services in a fashion that reduces cost and provides wider and more efficient processes for both the PHO's and the GP networks

Both of these partnerships are working well, meeting the strategic objectives set for them as well as operating profitably, ahead of budgets.

The executive structures continue to work well and all staff continue to showcase innovation and performance for the benefit of both the PHO and our community.

Once again, I'd like to thank the groups of people without whom our PHO would be unable to function. These include the Board who give their time and experience out of a sense of civic duty; Angela Francis, Chief Executive, the Management and staff who provide the energy and commitment needed to develop and deliver the services for our community; the many individuals who give up their time to participate in our advisory groups and; the Non-Governmental Organisations and organisations in the community providing essential health services in collaboration with our PHO.

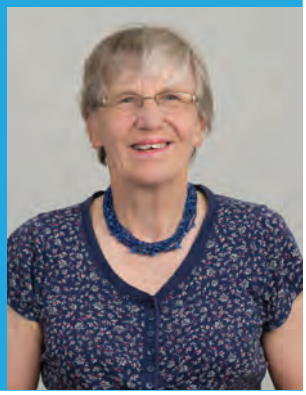
Nga Mihi,

John Hunter
CHAIRMAN

Sue Stubbs
PROVIDER REPRESENTATIVE

Sarah Green
PROVIDER REPRESENTATIVE

Stuart Hebberd
PROVIDER REPRESENTATIVE



Helen Kingston
COMMUNITY REPRESENTATIVE

Chief Executive's Report

> *Sustainability requires anticipating and responding to a changing environment and contributing to the wider wellbeing of our communities...*

Kia Ora Koutou,

For primary care health services to be sustainable, access to safe, effective and efficient services is key. Sustainability requires anticipating and responding to a changing environment and contributing to the wider wellbeing of our communities. It is our challenge to continuously think in a different way and do something different in order to achieve a different result.

Over the last year, some of Nelson Bays Primary Health's (NBPH) challenges have included

- Ageing population bringing increased demand, and the need for resource reallocation between services
- Ageing workforce
- Increasing risk (including lifestyles), incidence and complexity of long term conditions
- Increased ethnic diversity – refugees and migrants

- Persistent inequalities in access and outcomes for some groups in our community
- Risk factors for Māori & Pacific young people – particularly smoking and obesity
- Low health literacy levels
- Increased government expectations
- Increased IT demands as new models of care require new technologies, and advances in technology enable new models of care

These challenges were at the forefront of the Top of the South Health Alliance (ToSHA) agenda, of which NBPH is a member. Te Tau Ihu ToSHA is a formal partnership between Nelson Marlborough Health, Nelson Bays Primary Health, Marlborough Primary Health and Te Piki Oranga. Over the last year a programme of population health improvement and service transformation contributed to a joined up health service across the Top of the South. NBPH contributed as a partner of the alliance.

Over the last year, NBPH continued to focus on:

- A patient centered approach for all our services
- Influencing the social determinants of health where possible
- Health prevention/promotion
- Prioritising equity of health status between Māori and non-Māori
- Building relationships with Community Groups, Iwi and General Practice Teams

This resulted in a refinement of service design and delivery resulting in enhanced health status for the population as demonstrated throughout this report.

I would like to thank our staff; our key partners including General Practice teams; Nelson Marlborough Health and NBPH's community providers. I would also like to thank John Hunter, Chair of NBPH Board and the Board for their ongoing support throughout the last 12 months.

Nga Mihi,

Angela Francis
CHIEF EXECUTIVE

Clinical Governance

Committee Chair's Report

The Nelson Bays Primary Health (NBPH) Clinical Governance Committee met regularly over the 2016/17 year. The Committee has representation from General Practitioners, Primary and Practice Nurses, Practice Managers, Pharmacy, Māori health, as well as from the Board, Management and Nelson Marlborough Health. Over this last year we have been very pleased to have a Consumer Representative on the Committee.

The Clinical Governance Committee has a role in overseeing the clinical quality of services that are provided under NBPH. Over the year, the Committee has considered significant events, rural funding distribution, the Primary and Community Strategy, up-skilling of General Practitioners in skin lesion minor surgeries, and a new approach to clinical education, amongst many other topics. The Clinical Governance Committee aims to apply a quality lens over services alongside Te Tumu Whakaora who apply their Māori health lens.

This time period has seen the establishment and consolidation of patient portals in General Practices and most recently the introduction of HealthOne, a shared care record view allowing better information sharing between primary and secondary care.

Our Clinical Governance Committee has been sharing key messages with Marlborough Primary Health and Nelson Marlborough Health's Clinical Governance Committees in a move to a more unified approach across the top of the south.

The Clinical Governance Committee is also watching with interest the progress of a Health Quality and Safety Commission project about the quality of care patients receive after they have a heart stent. A number of the Committee members and their General Practices are involved in this project, including our Consumer Representative.

Sue Stubbs
CLINICAL GOVERNANCE COMMITTEE CHAIR

Te Tumu Whakaora

Chair's Report

It gives me great pleasure to present this report on behalf of Te Tumu Whakaora. Thanks to prioritisation of engaging with Te Ao Māori during the year, Te Tumu Whakaora was able to support Nelson Bays Primary Health's (NBPH) services to further develop their responsiveness to Māori.

Highlights include:

- Maintaining the focus on Māori who are for all intents invisible in the current data collection methods. Challenging the health system to continue to engage with those that would benefit the most from health systems that understood and responded to their needs
- The endorsement of both the NBPH Board and Clinical Governance Committee to raise items with the Ministry of Health regarding System Level Measures and how there are unintended negative consequences for Māori in applying this approach
- The increase of membership attending the Clinical Governance Committee. This allows the opportunity for meaningful input to inform clinical conversations

I have the utmost appreciation of the work undertaken by our membership, who provide valuable insight to the areas of strength and pockets of challenge within our district. The roopu has performed solidly to provide internal support, respond to identified community needs and provide a strengths based perspective that is necessary to move mainstream service to work effectively within a Māori mindset. Many thanks to these wonderful and busy people who make time to provide their expertise – every hui has a vibrant conversation. Nga mihi nui ki nga mema o te roopu o Te Tumu Whakaora. Mauri ora!

Lisa Lawrence
TE TUMU WHAKAORA CHAIR

Our Team

Executive Leadership Team

Our Team

Management Operations Team

Joint Ventures

HEALTH SYSTEMS SOLUTIONS

Health Systems Solutions Limited (HSS) is a collaboration between the shareholding entities Nelson Bays Primary Health, WellSouth Primary Health Network, Rural Canterbury Primary Health Trust and Kara Data Management Limited, with other South Island Primary Health Organisations (PHO's) also associated.

Health Systems Solutions initially provided clinical programmes claims management and capitation based funding management to its three shareholding PHOs. Since its inception in July 2014, Health Systems Solutions has extended both its customer base and range of IT services. Today, Health Systems Solutions is providing services for five South Island PHOs, representing an enrolled population of approximately 540,000 people.

Health Systems Solutions' mission is to provide PHOs with a superior customer service experience and to deliver a collaborative IT strategy to its PHO customers.

PROGRESS

Health Systems Solutions seconded Kyle Forde, Well South CIO, as acting Chief Executive for 6 months.

Over the 2016/17 financial year, Health Systems Solutions increased their client base and broadened their product offering.

HSS now offers the following products:

- Full PHO claims management system, including web portal for general practice, pharmacies, podiatrist and other providers to submit their claims, and a completely revised PHO management system
- Cloud hosting, through our Revera reseller agreement, including hosting of virtual servers, cloud back-up and cloud storage systems
- Custom built database systems, such as a Mental Health Brief Intervention Service patient management system, a Skin Lesion Referral triage database system, and a Smoking Cessation Brief Advice call centre system

ACHIEVEMENTS

Over this period, the following notable achievements were made:

- Fully transitioned Christchurch PHO from their previous IT provider into a new system provided by HSS - including full server and infrastructure hosting, claims management and Brief Intervention Service patient management
- HSS became an authorized reseller of Revera hosted infrastructure products, and currently use these for hosting their own systems as well as some new clients; including Karo Data Management Ltd
- HSS Developed a number of new Claiming programmes and forms including; Enhanced Capitation, Pipelle Biopsy, Options for Care, Comprehensive Health Assessment

Health Systems Solutions is providing services ...representing an enrolled population of approx. 540,000 people

URGENT & AFTER HOURS MEDICAL CARE

98 Waimea Road
8am - 10pm daily

For MEDICAL ADVICE after 10pm
Phone: 03 546 8881

MEDICAL AND INJURY CENTRE

The Medical and Injury Centre Limited is an equal joint partnership between Nelson Bays Primary Health and the General Practice Network in the Nelson region, represented by Nelson Bays General Practice Limited.

The Medical and Injury Centre provides a high quality and accessible urgent after hours medical service for the population of greater Nelson, in addition to also operating as a General Practice with an enrolled population. The Medical and Injury Centre is open seven days a week from 8am to 10pm, and is located next to the Emergency Department (ED) of Nelson Marlborough Health on 98 Waimea Road.

The Medical and Injury Centre's mission is to provide exceptional medical services to residents and visitors of the Nelson Bays area, alongside our General Practice partners and the hospital, during the day and after hours.

PROGRESS/ACHIEVEMENTS

For the year ending June 2017, there were 24,348 patients seen compared to 23,432 patients seen the previous year. The Medical and Injury Centre also entered into a pilot with Nelson Marlborough Health to work even closer together with the Emergency Department so that patients are seen by the appropriate service and long waiting times can be avoided. The Medical and Injury Centre has also employed a Nurse Practitioner to manage people's health needs in collaboration with other health care professionals. The Medical and Injury Centre has maintained both Cornerstone and Urgent Care Accreditation.

The Medical and Injury Centre entered into a pilot with Nelson Marlborough Health to work even closer together with ED so that... long waiting times can be avoided

Health & Safety Workforce

Health and Safety is an integral part of all contracts, services and programmes provided by Nelson Bays Primary Health (NBPH). NBPH has an agreed employee participation agreement at both localities, as well as volunteer Health and Safety representative committees.

DURING 2016/17:

- Committee meetings held bi-monthly per site
- Robust Health and Safety incident reporting, investigation and management online system
- Successful on-the-job health and safety training specific to individual roles and responsibilities
- Regular identification of hazards and management of these supported by the Health and Safety Committees, management and facility users
- Health and Safety Committee involvement in the updating of the two sites Business Continuity Plans and Emergency Management Plan
- Staff from both Golden Bay and Richmond sites completed Coordinated Incident Management Training (Level 4) which can be utilised during significant events and emergencies

EMPLOYEE AND WORKFORCE

Our Workforce as at 30 June 2017

One indicator of whether an organisation has a healthy and stable workforce is to compare the percentage of employees that leave the organisation on an annual basis, with national averages for the same industry.

Our achievement of a staff turnover rate of 12.8% which is **10% better** than **national average** in the Healthcare sector* showing the dedication and commitment of our team to their work, our organisation and to the community they serve is evident.

Here's a closer look at our current team composition.

149 Employees = **102** based at Golden Bay Community Health + **47** based in Richmond

- 15% are full time employees
- 85% are part time or casual employees

In the workplace survey themes, the most positive rating result since 2013 was achieved

EMPLOYEE ENGAGEMENT

The annual Employee Workplace Satisfaction Survey was completed in February 2017, and is a tool to check the health of our own organisation. The employee responses from this satisfaction survey confirm our organisation is on the right track, with the following results achieved.

- ✓ In the workplace survey themes, the most positive rating result since 2013 was achieved
- ✓ **86%** of question **satisfaction** rating averages were **positive**, scoring 4.0 or higher out of 6.0
- ✓ An increase in staff satisfaction ratings was evident in both Richmond and Golden Bay locations

The top three positively rated workplace themes were:

1. My Team
2. Performance and Feedback
3. The Person I Report To

*Source: The New Zealand Staff Turnover Survey 2016, Lawson Williams in partnership with Human Resources Institute of New Zealand.

Key Relationships

Nelson Bays Primary Health's (NBPH) stakeholder relationships are valued. The activity over the last year is, in all cases, supplemented by routine day-to-day operational engagement at other levels of the organisation and included:

- The range of Community Groups engaged with NBPH over this financial year, the support provided and the ongoing relationship maintained
- The range of Subcontracted Providers of which all have been visited with their contracts reviewed
- NBPH's contestable funding pool, its allocations and pending support for future bids
- NBPH devolved contract services to community groups in this financial year
- Primary and Community Strategy – the considerable community and consumer engagement undertaken resulted in the development of the Primary and community Strategy

The aforementioned activities and efforts resulted in a high number of AGM Attendees as well as improved Stakeholder Survey Results for the period 1 July 2016 – 30 June 2017.

High priority stakeholders also include Nelson Marlborough Health, Iwi and General Practices.

DISTRICT HEALTH BOARD

As a significant stakeholder with a high degree of power, the relationship with our DHB is critical and it is pleasing to note the level of engagement in this regard.

IWI

NBPH undertook visits to each iwi to maintain a proactive 2-way relationship and support awareness-raising of NBPH's role and work programme, underpinned by NBPH's Treaty obligations.

GENERAL PRACTICES

The Chief Executive and team undertook bi-annual visits to each individual practice to maintain a proactive 2-way relationship with practice owners and their practice teams. This action supplements the clinician-to-clinician engagement undertaken by the NBPH Board and associated clinicians (such as the chair of Clinical Governance Committee, the Medical Director and supporting clinical champions on NBPH committees and working groups). This has proved effective as demonstrated by the stakeholder feedback in the recent stakeholder survey.

From these visits, NBPH gains an insight on the community needs from the general practice perspective and can focus on promoting improved outcomes within its wider circle of influence.

COMMUNITY GROUPS

In addition to the above stakeholders, the Chief Executive and management undertook a roadshow meeting with 19 community groups. In addition, Management took all opportunities to attend relevant community meetings to ensure a high profile and two-way dialogue with the enrolled population (this specifically includes remote communities such as Collingwood and Golden Bay). The added benefit of these visits and meetings was to give our community groups and their members a welcoming face and an invitation for them to approach NBPH if they wished to discuss anything either "Face to Face" OR person to person. This action supplemented the specific community engagement work undertaken by NBPH Board Directors.

Key Relationships

NBPH CONTESTABLE FUNDING POOL

NBPH has a contestable funding pool that community groups may apply through to secure small amounts of funding. There are some organisations that NBPH has direct contracts with for more significant initiatives. Funding recommendations were based on available funding. The last year's budget restricted capacity. All of our community groups were eligible for the contestable funding.

Community Groups that have been directly funded by NBPH for workforce development within the financial year included:

- Lifeline Nelson
- Alzheimer's Society
- Post-natal support network Nelson
- The Male Room
- NZ Association of Physiotherapists wanunga
- Free Church of Tonga – Fanau Wellness Programme
- Victory Boxing Charitable Trust

In addition NBPH worked with a number of community groups to complete community initiatives applications for various support (including non-financial support).

PRIMARY AND COMMUNITY STRATEGY – COMMUNITY AND CONSUMER ENGAGEMENT

There were a number of meetings held over the last financial year which not only provided critical input to the design of the strategy but also demonstrated the strong connection, Nelson Marlborough Health (NMH), Marlborough Primary Health and NBPH has with its community stakeholders. These meetings were held in the months of October 2016 and May 2017 respectively.

AGM ATTENDEES

At the 2016 AGM it was pleasing to note the level of interest and engagement with many of our community groups.

STAKEHOLDER SURVEY RESULTS 1 JULY 2016 – 30 JUNE 2017

It was useful to consider the impact, if any, of NBPH's revised approach to community engagement. The survey indicated that a total of 98 stakeholders participated in the 2017 survey, an increase of 21% when compared to 2016 participation. There was a higher participation rate from Community Organisations evident in 2017, with 26.5% of respondents representing this sector compared with 15.2% in 2016. This increased participation indicates the growth of NBPH profile in this community sector over the last 12 months.

Feedback included:

- NBPH Making a Difference – The vast majority (91.5%) of respondents acknowledge the work of NBPH makes a positive difference in the community (rating 3 or higher out of 5); 59.1% rated this positive difference highly, with either a 4 or 5 rating (out of 5)
- Overall Satisfaction – The majority (78.9%) of the 71 respondents to this question indicated a better level of satisfaction, with 63.4% being somewhat or very satisfied
- Comparison to 1 year ago – The majority (71.7%) of respondents felt that NBPH had improved, with 19.4% reporting this improvement to be more than slight
- Staff Contact – Respondents ratings improved in both frontline/reception and core services staff, achieving satisfaction ratings of 5.53 and 4.95 out of 6 respectively

Health Services

Community Services

Our experienced staff and contracted service providers deliver a range of services for people in the community.

- Community Funding
- Pre-Diabetes
- Diabetes (type 2)
- Emergency Contraceptive Pill
- Falls Prevention
- Immunisation
- Gateway Assessments
- Green Prescription
- Healthy Hearts
- Health Targets in Primary Health Care (System Level Measures)
- Kaiatawhai Service
- Lactation and Breast Feeding Support
- Māori Health
- Mental Health Brief Intervention Service
- Osteoarthritis Self-Management (The Joint Programme)
- Primary Care Dietitians
- Pain Service
- Smoke Free Education
- Strengthening Families
- Youth Alcohol and Drug/Mental Health Counselling Service

General Practice

Care Plus

PURPOSE To provide funding to Nelson Bays Primary Health (NBPH)-aligned general practices so they can support people with high health needs due to chronic conditions, acute medical or mental health needs, or terminal illness. Care Plus is a national primary health care initiative, first rolled out in July 2004.

OBJECTIVE

- To improve a patient's chronic care management through better understanding of their conditions and support to make healthy lifestyle changes
- To reduce inequalities, a percentage of Care Plus places must be allocated to deprived people, and Māori and Pasifika people
- To improve primary health care teamwork
- To reduce the cost of services for high needs patients

PROGRAMME OVERVIEW

Eligible patients are offered an initial comprehensive assessment where their health needs are explored in more depth. An individual care plan is developed to set realistic, achievable health and quality of life-related goals, with follow-up appointments to monitor progress. Practices are able to maximise the use of Care Plus by using both short and long term packages of care depending on individual patient needs. A package of care consists of up to 4 appointments and each patient is able to utilise up to 2 packages of care per year. Claims are made electronically via the Practice Management System.

Care Plus is a highly utilised programme and the flexibility of the short term and long term packages support patients when they most need it...

ELIGIBILITY CRITERIA

A person is eligible for Care Plus if they are enrolled with their practice, eligible for funding and they are assessed by a doctor or nurse at their general practice as being able to significantly benefit from intensive clinical management in primary health care (at least two hours of care from one or more members of the primary health care team), and either:

*Has, **or is at significant risk of developing,** two or more chronic health conditions, so long as each condition is one that:*

- is a significant disability or has a significant burden of morbidity; and
- creates a significant cost to the health system; and
- has agreed and objective diagnostic criteria; and
- continuity of care and a primary health care team approach has an important role in management; or
- has a terminal illness (defined as someone who has advanced, progressive disease whose death is likely within 12 months); or
- has had two acute medical or mental health-related admissions in the past 12 months (excluding surgical admissions); or
- has had six first-level service or similar primary health care visits in the past 12 months (including emergency department visits); or
- is on active review for elective services.

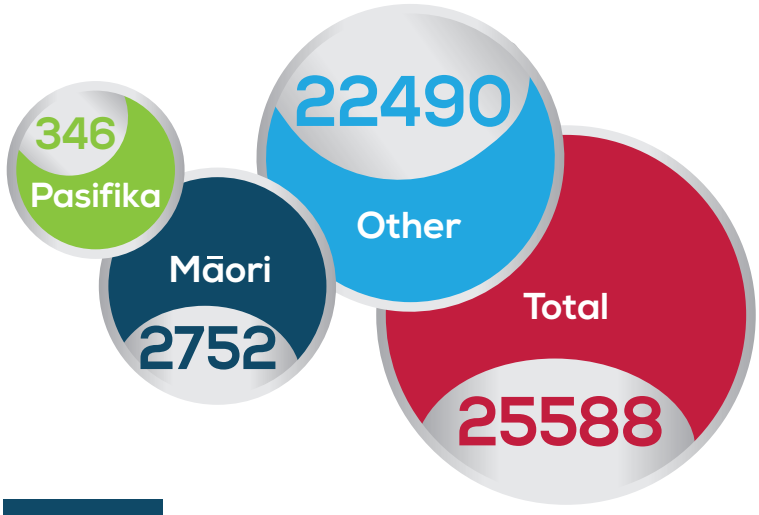
PERFORMANCE

Care Plus is a highly utilised programme and the flexibility of the short term and long term packages support patients when they most need it. Practices all utilise their allocations to the maximum.

There were 16,860 reviews in the past year and 6900 registered from an available funding pool of 6912.

There were 6990 patients enrolled on Care Plus for the 2016/17 year

THOSE ACCESSING CARE PLUS BY DEPRIVATION	NUMBER	% OF TOTAL REGISTRATIONS
No recorded Quintile	776	3%
Quintile 1	2831	11%
Quintile 2	5195	20%
Quintile 3	6346	25%
Quintile 4	6472	25%
Quintile 5	3968	16%



CURRENT REGISTRATIONS BY ETHNICITY	NUMBER	PERCENTAGE
Māori	2752	11%
Pasifika	346	88%
Other	22490	1%

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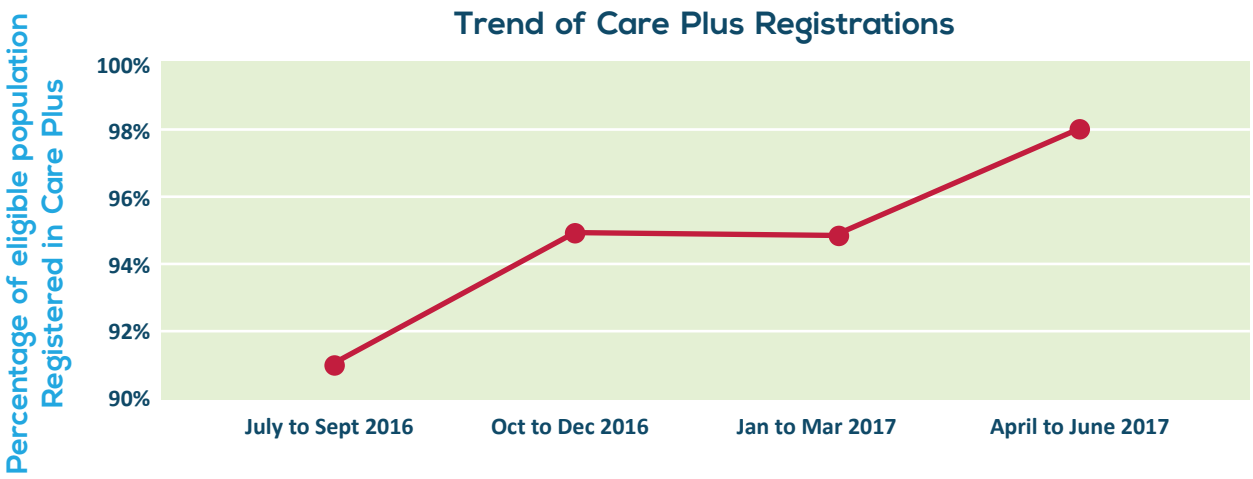
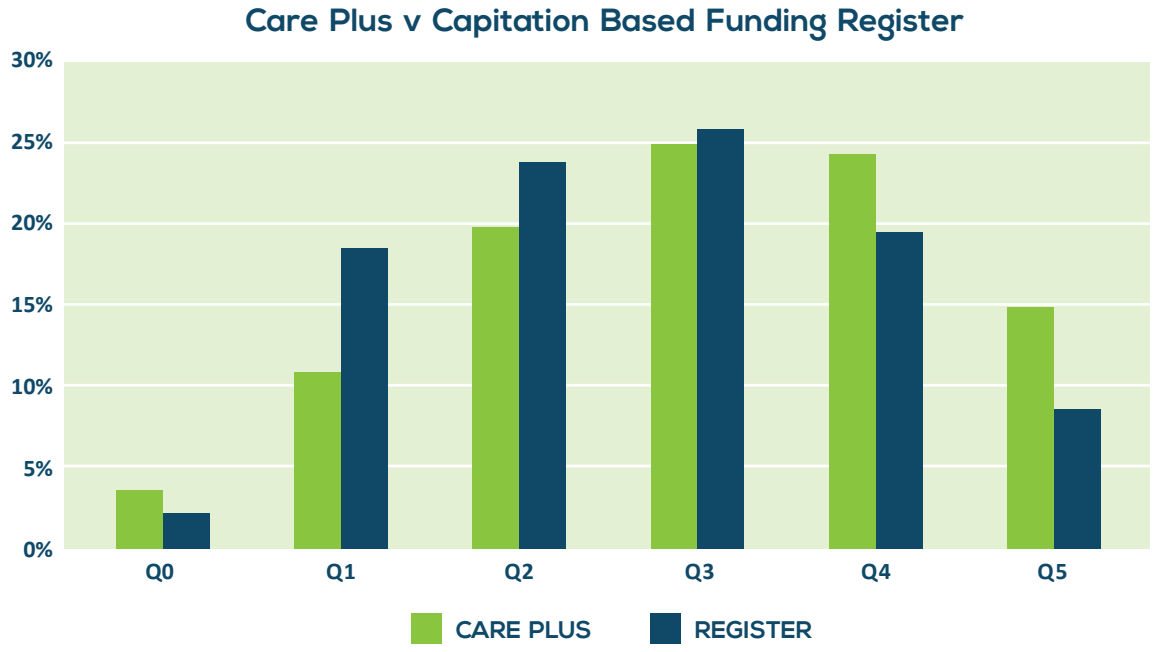
Care Plus

PERFORMANCE *continued*





Analysis of Care Plus enrolments compared to the Capitation Based Funding (CBF) Register showed that people residing in quintiles four and five had proportionally higher enrolment than those in the other quintiles thus the programme is targeting those with greater needs.

MAORI HEALTH ACTIVITIES

The NBPH Care Plus programme had 2752 (11%) Māori registered at the end of this year. There were 1601 Care Plus Reviews for Māori clients. Māori represent 8% of the total population, thus indicating that greater numbers of Māori are accessing Care Plus.

Community-Performed

Skin Lesion Removal Service

PURPOSE To provide skin lesion removal services closer to people's communities to reduce unnecessary demand on hospital services.

OBJECTIVES

- Applying the skin lesions pathway and thresholds when determining further actions required for referrals
- Providing constructive feedback and advice to referrers
- Forwarding referrals as appropriate to other General Practitioners for completion of procedures that are consistent with agreed standards
- Forwarding referrals as appropriate to Nelson Marlborough Health's surgical out-patients department for completion of procedures that are consistent with agreed standards
- Managing service quality, funding, contracts and payments
- Up-skilling the general practice network, where appropriate
- Developing and implementing a quality framework to measure the appropriateness, clinical quality and outcomes of community performed procedures, including audit of histology reports, quality of surgery (incomplete excision), complication rate and percentage of malignant pathology

PROGRAMME OVERVIEW

The service includes a General Practice Advisor and Specialist Dermatologist receiving, triaging and prioritising all referrals for skin lesion removal from general practice and providing high level advice on management of all lesions referred.

PERFORMANCE

Over the last year, Nelson Bays Primary Health noted an ongoing growth in referrals. This was combined with a Continuing Medical Education (CME) session focusing on the integration between primary, secondary and specialist services, has further consolidated the service across the general practice network.

The GP specialist, along with his colleague, have also completed further training and supervision with secondary care consultants and higher education. This allowed for more complex intermediate lesions to be seen in primary care and with appropriate resourcing, reduced demand on secondary care services.

continues over...

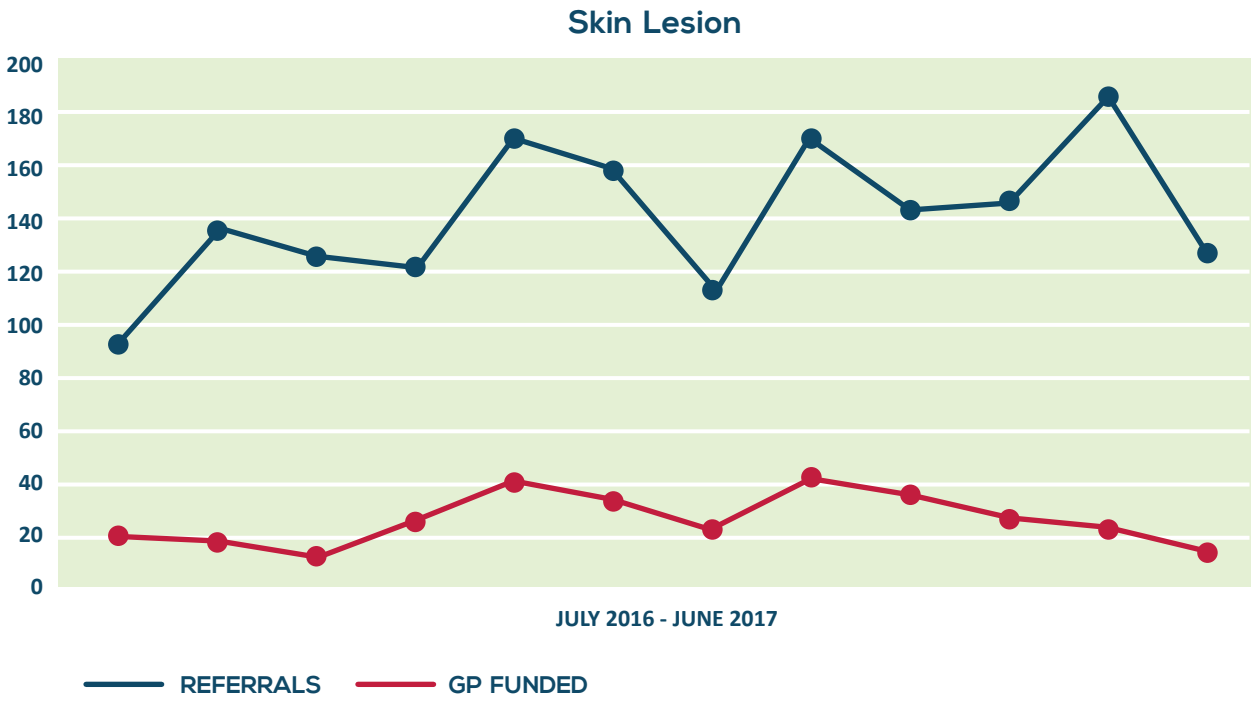
The new co-pay option allowed a greater number of patients to be supported with removal of skin lesions thus reducing secondary care demands

Community-Performed

Skin Lesion Removal Service

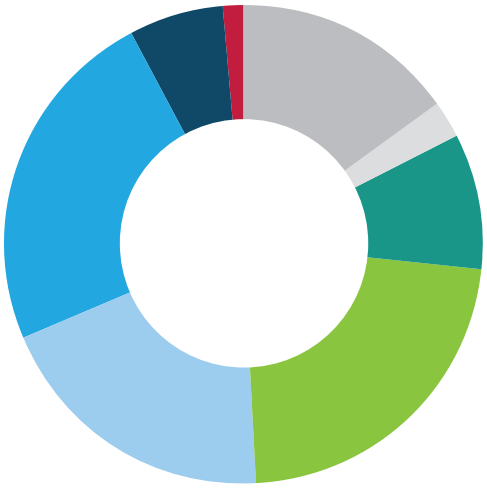
PERFORMANCE *continued*

Graph 1 Demonstrates the fluctuations in referrals that aligned to the quarterly funding that was available. It also demonstrates a higher utilisation with the new funding model introduced January 2017.



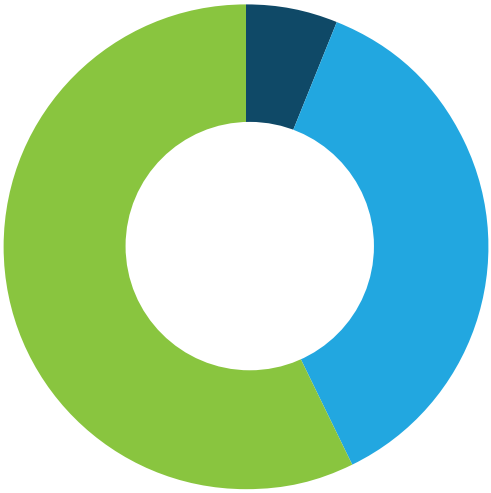
ETHNICITY BREAKDOWN FOR ALL REFERRALS	Q1	Q2	Q3	Q4	YEAR END
Māori	16	15	4	7	**42**
Asian	2	0	3	4	**9**
NZ European	395	384	388	371	**1538**
Pacific Island	0	1	1	1	**3**
Not Specified	27	46	25	22	**120**
Other	0	1	1	0	**2**
Total	**440**	**447**	**422**	**405**	**1714**

The majority of referrals for this service are for NZ European making up 89.7% of the referrals. Māori consist of 2.4% of the referrals.



Triage Destination of Referrals Received

- GP Funded
- ENT
- General Surgical
- Advice Only
- Dermatology Dept.
- Other
- Declined
- Not Triaged Yet



Triage Destination GP

- GP Funded Referrals
- Advice Only
- Declined

TRIAGE DESTINATION OF REFERRALS RECEIVED	Q1	Q2	Q3	Q4	YEAR END
Advice Only	76	67	63	53	**259**
Declined	10	8	10	15	**43**
Dermatology Dept.	32	45	40	37	**154**
ENT	89	102	104	89	**384**
General Surgical	87	88	81	77	**333**
GP (Funded)	104	73	113	114	**404**
GPSI (Funded)	-	-	-	1	**1**
GP Insufficient Info	1	2	-	1	**4**
Not MSLSS	0	1	-	0	**1**
Other	41	56	6	5	**108**
Not Triaged Yet	0	5	5	13	**23**
Total	**440**	**447**	**422**	**405**	**1714**

GP funded referrals comprised of 23.6% of Total referrals, Advice only 15.1% Declined 2.5%
(GPSI -General Practitioner with Special Interest)

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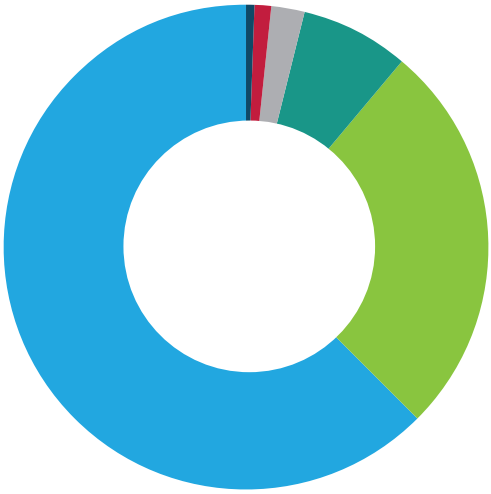
Community-Performed

Skin Lesion Removal Service

PERFORMANCE *continued*



AGE FOR ALL REFERRALS	Q1	Q2	Q3	Q4	YEAR END
0 - 4 years	4	0	5	1	**10**
05 - 14 years	8	8	4	2	**22**
15 - 24 years	9	6	14	6	**35**
25 - 44 years	28	42	32	24	**126**
45 - 64 years	108	136	106	102	**452**
65+ years	283	255	261	270	**1069**
Total	**440**	**447**	**422**	**405**	**1714**

The majority of referrals for this service are for those over 65 years- 62.3% of referrals.
Those aged between 45–65years comprise of 26.3%.

OUTCOMES HOW WELL DID WE DO? **KEY PERFORMANCE INDICATORS**

The wider spectre of quality has been in focus, with a concentration of histology, appropriate margins and support from the GP Advisor and the Specialist Dermatologist who support the service.

There have been 434 GP funded removals for the last financial year. The new co-pay option allowed a greater number of patients to be supported with removal of skin lesions thus reducing secondary care demands.

Cameras were provided to practices to improve image analysis and support effective triage which has been working successfully.

Professional Education

Continuing Medical Education

PURPOSE To provide high quality Continuing Medical Education (CME) for NBPH-aligned general practitioners, by funding and supporting a Royal New Zealand College of General Practitioners (RNZCGP) approved CME programme and CME Facilitator, to maintain approved provider status.

OBJECTIVE

To ensure:

- That Nelson Bays General Practitioners (GPs') skills, knowledge, attitude and professional judgment are enhanced to improve the health care of this region's population
- That Nelson Bays GPs are exposed to high quality CME that meets the RNZCGP standard to maintain and improve their skills and clinical performance
- That the identified learning needs are met and to ensure relevant necessary qualifications are maintained
- That Nelson Bays GPs are kept up-to-date with current best practice and evidence-based medicine
- That SMART principles (Specific, Measurable, Achievable, Realistic and Timely) are applied to learning objectives

PERFORMANCE

CME is currently undergoing some major changes in the delivery of learning packages rather than a theatre style lecture education session. Over the last financial year, the new Pegasus small group model was under development with the first sessions planned for August 2017.

More focus is being placed on combined learning sessions, workshops and hands-on learning as we move to the next years revised model. Online learning is also more of a shift as training opportunities become available on this platform. In line with this shift in focus, the Education Committee rebranded as 'The Learning Support' Team.

CME is currently undergoing some major changes in the delivery of learning packages... with the new Pegasus small group model sessions planned for August 2017

Professional Education

Continuing Medical Education

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The following CME sessions were held over the last year:

DATE	TOPIC	PRESENTER(S)	ATTENDEES	RATING
27.7.16	COPD in General Practice Combined Education Session	M Sherif, J Jones, S Alsop	19	55/100%
17.8.16	GP Registrar Clinical Audits		14	83/100%
21.9.16	Lab Tests Combined Education Session	L Merriman, J Elvy, T Barnett, G Warren, M Myskow, Shone Brougham	21	59/100%
25.10.16	Skin Lesions Update	Dr Peter Sears, Dr Susan Seifried, Mr Mike Roberts, Dr Michael Myskow	46	70/100%
29.11.16	New concepts in COPD Management 2016 - Spirometry Interpretations (Combined)	Prof Lutz Beckert	14	76/100%
8.12.16	General Practice Upper Limb Injuries, Dinner & Workshop	Dr Prasangi Wimalasena, Mr Angus Jennings, Andrea Chapman	27	80/100%
20.2.17	Acute Eye Care Workshop	A Suter, D Sherwood, R Jones, E Conner	30	80/100%
1.3.17	Rheumatology	D Porter, Rheumatology Team	33	78/100%
11.5.17	GP Lower Limb Injuries	Dr Prasangi Wimalasena and Mr Angus Jennings	20	81/100%
12.6.17	Multi Morbidity & Health of Older People	M Ball, R Blackbeard, H Burbidge, C Arkless, M Peters	20	72/100%
24.6.17	Same old or something different, own our future as GPs Focus Group workshop		35 27	70/100%

Professional Education

Continuing Nursing Education

PURPOSE To provide the primary health care nursing workforce of Nelson/Tasman with access to quality on-going professional development relevant to the health needs of our population, ensuring clinical excellence and patient empowerment.

OBJECTIVE

- To ensure a competent nursing workforce able to meet the challenges of primary health care now and into the future
- To promote multidisciplinary and collaborative approaches to health care delivery
- To promote the use of self-reflection and portfolio development
- To promote patient safety and on-going quality improvement

PROGRAMME OVERVIEW

Professional development is an on-going requirement for nurses as prescribed by the Health Practitioners Competence Assurance Act (HPCAA). The Act's principal purpose is to protect the health and safety of the public by ensuring health practitioners are fit and competent to practise. Legally, Registered Nurses need to demonstrate at least 20 hours per year (or 60 hours over 3 years) of Professional Development. A locally delivered programme allowing nurses to attend outside of their working hours is essential to ensuring access and equity.

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The Continuing Nursing Education (NE) calendar is determined by nurses every year. NBPH organise the topics and speakers in accordance with this calendar.

Demand for education forums outside of the CNE structure remains strong and well received. Nelson Bays Primary Health (NBPH) provided a variety of training and development options, including, but not limited to, expert speakers, provision of practical workshops, online training and support for external education providers with national programmes brought to Nelson/Tasman.

Nurses were able to attend the combined education sessions allowing a good platform for inter-professional development with GP's and Pharmacists for aligned messaging from learning opportunities.

There was funding available for nurses to access conferences and learning of up to $500 per nurse per year, with a funding pool cap. This supported further learning and professional development opportunities.

NBPH along with Marlborough Primary Health appointed a Director of Primary Care Nursing position over the last year to the region to support nurses with their professional development portfolios. This role is already demonstrating good engagement with practice nurses.

Demand for education forums outside of the CNE structure remains strong and well received

Professional Education

Continuing Nursing Education

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The following Continuing Nursing sessions have been held in this year:

DATE	TOPIC	PRESENTER(S)	ATTENDEES	RATING
27.7.16	COPD in General Practice Combined Education Session	M Sherif, J Jones, S Alsop	24	55/100%
23.8.16	Growing Healthy Habits in Children	N Johnson, T Talbot, B Holdaway	15	80/100%
7.9.16	Survivorship – *Understanding and supporting Cancer Survivors in General Practice*	Dr K Gregory, K Taylor, G Dowse	10	80/100%
21.9.16	Lab Tests Combined Education Session	L Merriman, J Elvy, T Barnett, G Warren M Myskow, Shone Brougham	17	59/100%
14.10.16	Spirometry Workshop for NBPH Providers	Judy Jones, Neil Gover	15	94/100%
27.10.16	Nursing PHOcus Meeting	Yvonne Youngman		12
31.10.16	Suturing Workshop	Emma Bonnington	12	94/100%
28.11.16	Beginners ECG Workshop	Jennifer Hassloch	11	95/100%
29.11.16	New concepts in COPD Management 2016 - Spirometry Interpretations (Combined)	Prof Lutz Beckert	14	76/100%
6.12.16	Suturing Workshop	Emma Bonnington	13	91/100%
13.12.16	IV Therapy Workshop	Andrea Chapman	5	
21.3.17	Raising Healthy Kids: Childhood Obesity Target	N Johnston, T Talbot	15	83/100%
20.4.17	PHOcus Meeting		8	
12.6.17	Multi Morbidity & Health of Older People Combined Education Session	M Ball, R Blackbeard, H Burbidge, C Arkless, M Peters	18	72/100%
27.6.17	Spirometry Update	J Jones	19	n/a

Professional Education

Quality Education

PURPOSE To support high quality Practice Manager/Administrator, GP and Practice Nurse education in order to enhance the quality of leadership, systems and processes within general practice. Aligned also to the Cornerstone Aiming for Excellence framework, Quality Education, this supports quality standards for the whole practice team.

OBJECTIVE

- To identify and prioritise learning needs of Practice Managers/Administrators as indicated by a needs-based learning assessment
- To identify and prioritise Cornerstone requirements to support practices achieve their accreditation
- To develop and deliver an Annual Education Plan, based on the learning needs assessment and within the budget allocated
- To recruit appropriate expert presenters to deliver quality education sessions on identified learning needs
- To deliver education in an equitable manner to rural practices
- To ensure educational messages are consistent
- To ensure education is relevant and aligned to NBPH goals and the goals of the Primary Health Care Strategy
- To collaborate with Nelson Bays Primary Health (NBPH) staff to maximise education sessions and to avoid duplication of sessions or over-committing practices to education sessions
- To collaborate within the Learning Support Team to deliver multidisciplinary education sessions when appropriate

PROGRAMME OVERVIEW

QED are combined learning sessions for the practice teams usually with an invited speaker in a variety of formats including workshops and sessional. There are also online training opportunities for some topics (e.g. Privacy) that are available and shared for practice teams to access.

Practice Manager Specific Education is delivered by the Practice Managers and Administrators Association of New Zealand (PMAANZ), Nelson Branch. They have developed an Education Calendar, which includes a subsidy for attendance at the national PMAANZ Conference for all NBPH-aligned practice managers, administration and reception staff. PMAANZ education also includes competency levels (Bronze, Silver, Gold) to further support development of the administrative team and practice managers. Each PMAANZ affiliated practice is able to access funding up to $100 per year to support further PMAANZ education for their administrative team.

NBPH continues to facilitate bi-monthly Practice Manager Meetings to canvas administrative issues in general practice, and to provide NBPH support to troubleshoot these as they arise. The feedback from these meetings is that they are a great way to network for the Practice Managers, to have maximum opportunity to provide input and to strengthen NBPH's relationship with general practices.

Each PMAANZ affiliated practice is able to access funding up to $100 per year to support further PMAANZ education for their administrative team

Professional Education

Quality Education

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The following Quality Education sessions have been held in this year:

DATE	TOPIC	PRESENTER(S)	ATTENDEES
5.9.16	Cultural Competency	L Katu	36
12.9.16	Te Tiriti o Waitangi	L Katu	23
10.10.16	Live Demonstration of NZ ePrescription Service	Ministry of Health	51
22.11.16	Medtech Advanced Training	Judy Gilmour	6
29.11.16	Medtech Advanced Training	Judy Gilmour	4
27.2.17	Emergency Response	P Kara	46
21.2.17	Overview of the Due Diligence and Outcomes Intrahealth and Profile PMS	Pegasus Health	15
7.3.17	Primary Care Patient Experience Survey	Richard Hamblin HQ&SC	6
3.4.17	Te Tiriti o Waitangi	L Katu	21
6.4.17	Te Tiriti o Waitangi	L Katu	32
12.4.17	Cultural Competency	L Katu	18
19.4.17	Te Tiriti o Waitangi	L Katu	7
1.5.17	Infection Control	B Harris	56
30.5.17	Te Tiriti o Waitangi	L Katu	12
1.6.17	HealthOne GP and Community Pharmacy Forum	Dr Wilson	54
19.6.17	Cultural Competency / Refugee	B Whitaker	34

Free After Hours

Under Thirteens Funding

PURPOSE On 27 October 2011 the previous Minister of Health, Tony Ryall, announced that "free visits to the doctor for children under six would be extended to after-hours". This policy was rolled out across the country from 1st July 2012. The funding for this initiative was negotiated with Nelson Marlborough Health to within existing funding for the region.

By the end of July 2012, 93% of children aged under six were receiving free doctors' visits during the daytime across 957 general practices across New Zealand. Over 90 per cent of children aged under six had access to free after-hours care within reasonable travel time for the same period. This compared to only 70 per cent of children received free visits in 2008.

On 1 July 2015, the previous Minister of Health, Tony Ryall, announced that "free visits to the doctor for children under 13 will be extended to after-hours".

OBJECTIVE

To affect 100% coverage for free under 13 services at after-hours providers in the Nelson Tasman region within its member practices according to the following criteria.

- After-hours is defined as outside of normal practice hours' weekdays, weekends and Public Holidays
- Casual patients are included in this criteria
- Patients must be under 13 years at time of presentation.
- After-hours coverage in Nelson at Medical and Injury Centre, Motueka and Golden Bay

Exclusions: ACC patients whom have a separate approach for under 13's afterhours care.

PROGRAMME OVERVIEW

The service promoted the importance of continuity of care at the child's regular general practice thus supporting the client's relationship with their medical home and thereby ensuring that after-hours services are used for urgent care and the Emergency Department is only used for emergency care.

On 1 July 2015, the previous Minister of Health, Tony Ryall, announced that "free visits to the doctor for children under 13 will be extended to after-hours"

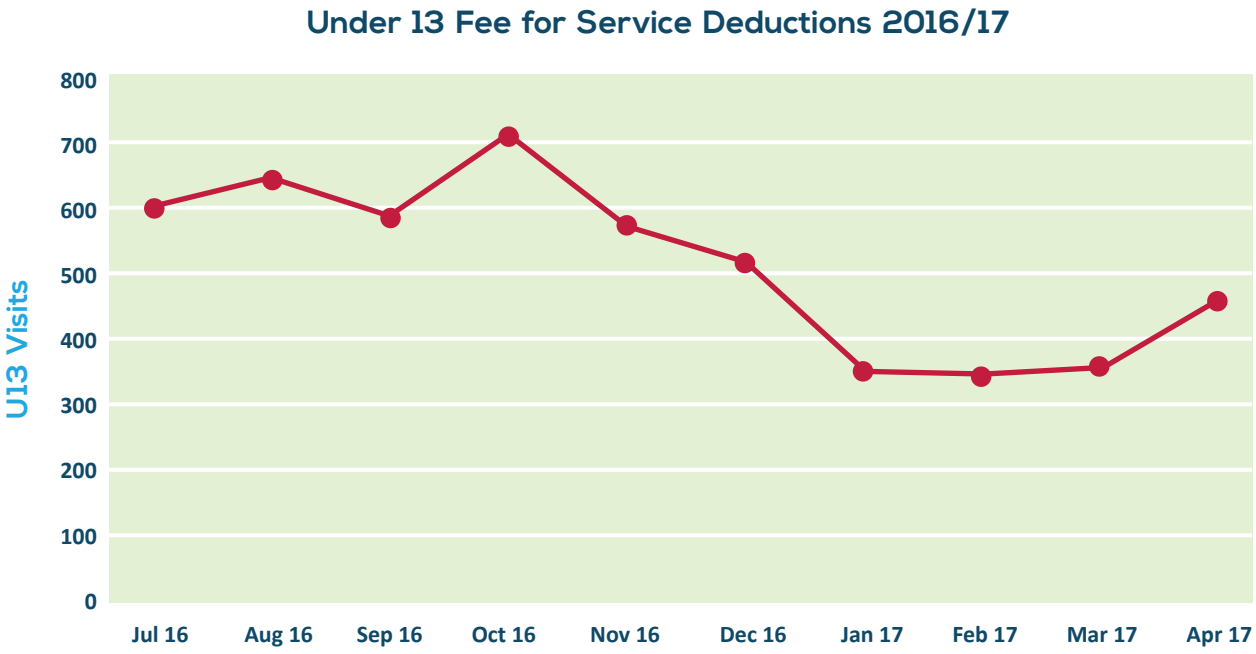
Free After Hours

Under Thirteens Funding

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

All Nelson Bays Primary Health (NBPH) affiliated practices and after-hours services have access into the free Under 13 funding scheme.

Graph 1 represents the "cycle" of fee for service (FFS) deductions for under thirteen-year old children both daytime and afterhours over time.



CONCLUSION

This service remains popular across the district with predictable seasonality clearly evidenced, with peaks around the July to November period.

Palliative Care

PURPOSE To assist Nelson Bays Primary Health (NBPH) affiliated general practices and patients, by providing payments to general practice teams directly, as reimbursement for visits in the home and/or consultations at the practice undertaken with patients in the last 6-12 months of their life.

OBJECTIVE

- To reduce the financial burden on the patient in the terminal phase of their illness.
- To optimise an individual's quality of life until death by addressing the person's physical, psychological, spiritual and cultural needs.
- To allow the GP to receive reimbursement for loss of income whilst administering to the terminal patient (GPs traditionally do not charge patients for visits during the terminal phase of their illness).
- To provide continuity of care by maintaining the relationship with the general practice team.
- To support the individual's family, whānau and other care-givers where needed, through illness and after death.

PROGRAMME OVERVIEW

This service is available to patients who have been diagnosed with a terminal condition and whose death is expected within the next 6-12 months.

Patients registered onto the NBPH Palliative Care programme are allocated a package of care, (with a separate agreement for those enrolled in rural Motueka and Golden Bay practices). All palliative care applications are received electronically by NBPH. Payment is made to general practice upon submission of an electronic claim to NBPH. Funding is provided for GP consultations, nurse consultations, home visits, discharge meetings and post death family visits. Patients are exited from the programme if they exceed the limit of their allocated funding or if they die.

PALLIATIVE CARE ACTIVITY 2016 / 17 FINANCIAL YEAR:

CONSULTATIONS	TOTAL FOR YEAR
GP Home Visit	421
GP Prescription	365
GP Consult	363
GP Hospice Visit	45
GP Post Death Visit	104
GP Other	101
Nurse Home visit	4
Nurse Consult	17
Nurse Prescription /Other	9
Total Consultations	**1429**

Home visits comprise the main component of the palliative care funding, closely followed by GP consultations and prescriptions.

Most nurse consultations are combined and tend to be recorded under GP consult.

Nurse prescriptions are slowly being introduced with the expanding scopes of some nurses and the introduction of the Nurse Practitioner pathway further supporting the practice team to manage palliative care patients.

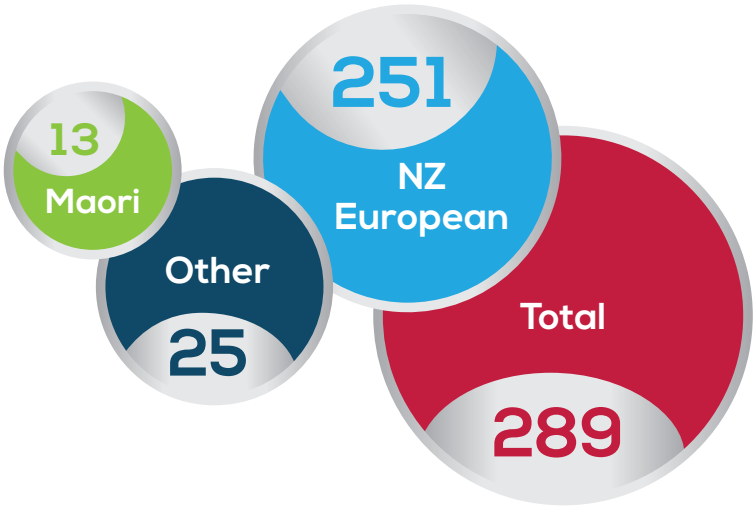
Nurse prescriptions are slowly being introduced ... supporting the practice team to manage palliative care patients

Palliative Care

DEMOGRAPHICS OF THE NEW REGISTRANTS:

GENDER	REGISTRANTS
Female	137
Male	152
TOTAL	**289**

ETHNICITY	REGISTRANTS
NZ European	251
NZ Māori	13
Other	25
TOTAL	**289**



K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

There were 302 patients registered on the Palliative Care Programme. During this past year 289 new patients accessed the service. The service is highly regarded by general practice.

MAORI HEALTH ACTIVITIES

There were only 13 new registrations to this service for people who identify as Māori during this past year.

Māori participation rates in the palliative care programme are lower than the average at 4.4%. This parallels participation rates in some other health support programmes relative to the population. It is unclear as to whether this should be seen as a problem, as when compared to the overall population the majority of the Māori population is relatively young, with almost 50% of Māori people being under the age of 25.

There is also significant support from Māori providers which many Māori whanau tend to access.

Primary Options For Care

PURPOSE Primary Options for Care was established in September 2016 out of a previous work-stream that had been developed to undertake actions to reduce hospital admissions. This new service was designed to ensure a longer term strategy for delivery of care in the primary settings, with resourcing provided.

OBJECTIVE

The overarching aim of the Primary Options for Care programme is to have a positive impact on health outcomes for patients and reduce the demand in secondary care services by empowering primary care providers to provide more flexible and responsive alternatives to services being provided in hospitals.

The community-based IV Therapy service that had been operating since October 2012 under the original strategy, was expanded into the Primary Options for Care programme.

PROGRAMME OVERVIEW

Table 1 (over) outlines the procedures offered to general practice. The service is available for all patients who are normally resident within Nelson Marlborough and enrolled with Nelson Bays Primary Health.

The overarching criteria for a patient to be eligible for Primary Options for Care are:

- That the patient otherwise would be referred to the hospital or other Nelson Marlborough Health funded specialist services for management but can safely and appropriately be treated and supported in the community.
- That the patient will require no more than 3-5 days of acute treatment and support.
- That the patient can be managed within the practice allocated Primary Options for Care budget determined for each service.

Exclusions include:

- Those people not normally resident within Nelson and Marlborough
- People receiving treatment to stabilise their condition before being transferred to hospital
- Services that are covered by ACC
- Services that can be covered by Care Plus

With expanded options available in the Primary Options for Care... the service will evolve to support general practice to further reduce demand on secondary services

- Those services that are already contracted for by Ministry of Health or Nelson Marlborough Health e.g. Maternity services
- Those people resident in aged care facilities

Many of these services have historically been provided in general practice for a fee. Service providers can charge a co-payment on top of the Primary Options for Care funding. Therapeutic Venesection for haemochromatosis and polycythaemia vera and Zometa infusions for metastaties are provided free to all service users. It is also expected that some patients will receive free services under this agreement with a focus on;

- Those with a community services or high needs health card
- High needs patients (Māori, Asian, Pacific or NZ deprivation index quintile 5)
- Others at the discretion of the service provider

The maximum co-payment must be published by the service providers. All Nelson Bays General Practices are participating.

Primary Options For Care

TABLE 1: SCHEDULE OF SERVICES

PRIMARY OPTIONS FOR CARE	1 JULY 2016 TO 30 JUNE 2017
Entonox	58
Haemochromatosis TV	249
Hyperemis	12
IV Antibiotics	238
IV Fluids for Dehydration	192
Management of DVT	9
Migraine	22
Paediatric Intranasal Fentanyl	21
Zolendronic Acid Infusions for metastases	4
Insulin Initiation	13
Spirometry - diagnostic	323
COPD Acute exacerbation management	16
Ad Hoc Services	14
Polycythaemia Vera	9
Primary Options For Care Totals	**1180**

PERFORMANCE

The table adjacent shows the numbers of services provided under the Primary Options For Care from September 2016 to end of June 2017.

The split appeared fairly even between male and female with only slightly more males who accessed the service.

5.6% of Māori accessed this service, 0.7% Asian and 0.3% Pacifica.

18.7% were registered as other ethnicity or had no ethnicity recorded. 74.4% were European.

Rurally located practices utilised this service significantly more than the urban located practices based on eligible service user numbers. There were 165 patients who had no co-payment charged via this service for the year.

A continued high number of Therapeutic venesections has been noted. This could potentially be due to patients coming up for review who had previously been discharged from regular venesection when the service was devolved from the Blood Bank.

Spirometry diagnostic continues to be very well utilised by all practices.

Ad Hoc services are increasing due to patients being discharged home earlier with requests from hospital specialists for management, such as cancer treatments that are able to be delivered in Primary care.

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

With expanded options available in the Primary Options for Care, and now with a patient co-payment ability, the service will evolve to have a wider reach for patients and support general practice to further reduce demand on secondary services.

Smoking Cessation

PURPOSE To provide funding to Nelson Bays Primary Health (NBPH) affiliated general practices to provide smoking cessation counselling with patients, within the General Practice setting at no cost to the patient.

OBJECTIVE

To support the Ministry of Health's target to provide "Better Help for Smokers to Quit", by identifying all current smokers enrolled in general practice and offering a free cessation service, within general practice, to those who are considered high priority smokers by the New Zealand Smoking Cessation Guidelines 2007.

PROGRAMME OVERVIEW

The Smoking Cessation programme consists of the following components:

- **Brief Intervention**
  - A brief assessment of a smoker's willingness to quit
  - Referral to an appropriate cessation programme if they are ready to quit
  - Provision of appropriate cessation messages if they are not ready to quit
  - There is no payment to practices for the brief intervention

- **Cessation Consultation**
  - Intensive consultation for those smokers referred after a brief intervention
  - Development of a quit plan, providing practical problem solving skills and offering nicotine replacement therapy or pharmacological treatment as appropriate

- **Follow-up**
  - Three follow-up consultations are recommended and are available for practice-based cessation services, at one week, four weeks and three months from the initial consultation or quit date
  - Follow-up can be via the telephone, face-to-face or other method as agreed between the provider and patient e.g. group session
  - Progress is monitored, psychological support offered and alternative treatment options discussed and prescribed as required
  - Practice teams may offer more support to a patient but this is not funded via this programme

The programme meets the *New Zealand Smoking Cessation Guidelines 2007*, encouraging behavioural and pharmaceutical support. It is currently targeting only high priority patient groups in general practice to allow the programme to keep within allocated funding. The programme is fully managed electronically through NBPH advanced forms, which provide an electronic means of gathering data, programme delivery and payment to practices. NBPH collects practice-level data to ensure the programme is delivered consistently and effectively within general practice.

Over the last year, NBPH continued to promote smoking cessation in support of the Ministry of Health's "Better Help for Smokers to Quit" target. The target was to ensure 90% of current smokers, who present to general practice, were offered smoking cessation support.

This programme is highly valued and utilised widely by primary care GP's and nurses.

The cessation rates for those completing the full "Smoking Cessation" programme for the past year was 46.67%

Smoking Cessation

ELIGIBILITY CRITERIA

All smokers are offered brief advice, however, to enter the funded NBPH Smoking Cessation programme (Cessation Consult and three follow-ups), patients must belong to at least one of the following high priority populations:

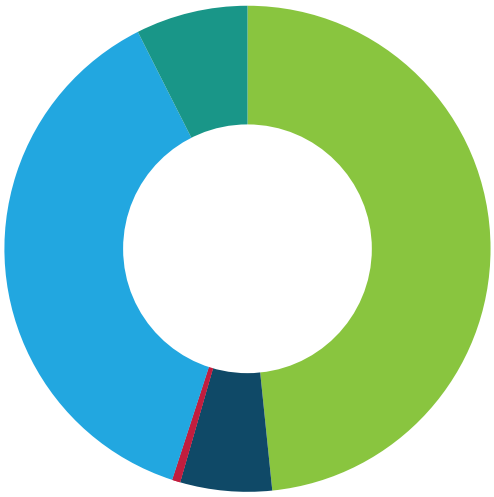
- Māori, Pasifika, Asian
- Geo-coded as living in quintiles 4 or 5
- Pregnant woman or household/whānau of pregnant woman
- Breastfeeding woman or household/whānau of breastfeeding woman
- Parents of children with chronic respiratory disease
- Pre-operative
- People with diabetes, respiratory disease or cardiovascular disease
- People who have a Community Services Card or are in receipt of unemployment, sickness or invalids benefit
- People who have recently been discharged from hospital who would like continuing support from general practice

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

There were 741 people who commenced the course this past year, of which 378 were male and 363 were female.

	TOTAL	GENDER		AGE				
		MEN	WOMEN	<15	15-24	25-49	50-75	>75
Asian	13	8	5	0	0	11	2	0
NZ European	490	260	230 (3 pregnant)	0	22	256	205	7
NZ Māori	165	72	93 (4 pregnant)	0	22	96	45	2
Other	57	30	27	0	2	32	23	0
Pasifika	16	8	8	0	2	12	1	1
Total	**741**	**378**	**363 (7 Pregnant)**	**0**	**48**	**407**	**276**	**10**

Treatment Prescribed at Initial Cessation Consultation



- Nicotine Replacement Therapy e.g patches
- Varenicline (Champix)
- Bupropion (Zyban)
- Nil
- Nortryptyline

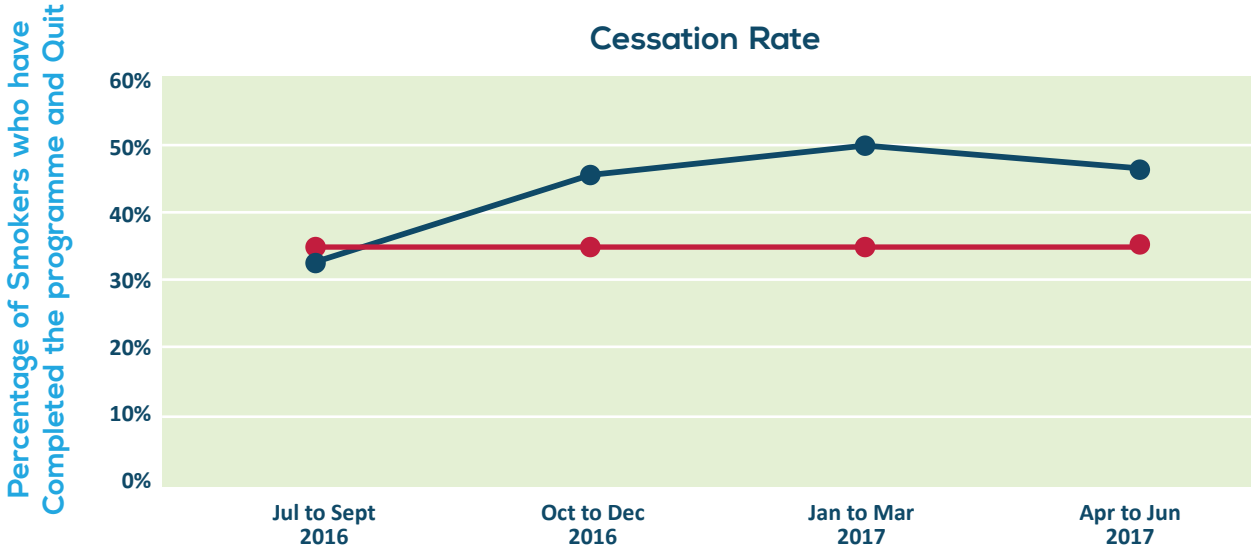
Pharmacological treatments were prescribed to 738 patients together with the offer of behavioural and emotional support.

Of the 237 people who completed the whole programme (4 sessions) in this past year, 101 reported they are now smoke free. A further 278 people had quit smoking prior to completing the full programme.

The cessation rates for those completing the full programme for the past year was 46.67%.

The Ministry of Health funding for Smoking Cessation programmes requires a minimum cessation rate (for self-reported cessation) of 35%.

Cessation Rate



	Jul to Sept 2016	Oct to Dec 2016	Jan to Mar 2017	Apr to Jun 2017
CESSATION RATE	32.89%	45.71%	50%	46.67%
MINIMUM REQUIREMENT	35%	35%	35%	35%

Smoking Cessation

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

TREATMENT SESSIONS PER SERVICE USER:

CONSULTATION TYPE	NO. OF SERVICE USERS	NO. REPORTING TO BE SMOKEFREE	NO. REPORTING A REDUCTION IN SMOKING BEHAVIOUR
Initial	741		
First follow-up	521	135	353
Second follow-up	378	143	220
Third follow-up	237	101	127

In the past year, there were 1877 consults and 5,071 follow-ups. The follow-up method was as follows:

FOLLOW UP METHOD	NUMBER OF FOLLOW UPS
Phone	3,329
In Practice Group Session	14
Other	82
Not Stated	531
In Practice Consult	1,115
Total	**5,071**

MAORI HEALTH ACTIVITIES

Of the 741 people who commenced this programme in this Year, 165 were identified as Māori (22.2%). Of the total Māori, 72 are tāne (male) and 93 are wāhine (female).

Māori people have a higher incidence of smoking than non-Māori, and a higher incidence of diseases associated with smoking, e.g. cardiovascular disease, therefore Māori people remain a priority for smoking cessation support.

NBPH will continue to promote smoking cessation and encourage general practices to offer culturally appropriate services and work with Māori health providers.

Smoking Cessation

ABC in Primary Care

PURPOSE To reduce the prevalence of smoking in the Nelson Bays region and reduce the harm to health caused by smoking.

A Ask if they smoke, and if they are smokers

B Offer Brief Advice

C Encourage Smoking Cessation Support

The ABC approach

OBJECTIVE

- To ensure smoking information is recorded, monitored and acted on by clinicians and healthcare workers
- To actively promote the **ABC** approach to smoking cessation in the Nelson Bays region, where all people are: **A**sked if they smoke, and if they are smokers, offered **B**rief Advice, and Smoking **C**essation support
- To ensure the ABC approach is integrated into everyday practice of all general practices so that an increasing percentage of their patients who smoke are provided with advice and help to quit
- To ensure practice management systems record smoking status and that data collection is robust, providing feedback and evidence of performance to practices
- To ensure training is provided to support staff to gain knowledge and skills to apply ABC effectively
- To ensure quality improvement strategies are applied to the programme
- To work collaboratively with Nelson Marlborough Health based and other community smokefree services to create a culture and environment that supports people to be smokefree and supports smokers to make Quit attempts

PROGRAMME OVERVIEW

The 'Implementation of Smoking Cessation ABC in Primary Care' programme takes multiple approaches to achieve its objectives of upskilling general practice in the ABC approach to smoking cessation: embedding practice management systems and IT to manage and collect data; using train-the-trainer education techniques offered in-practice by the Smokefree Facilitator; linking general practice to external smoking cessation providers using clear referral pathways; linking with DHB-based secondary care Smokefree Coordinator to ensure a transition from general practice to hospital and back to general practice with a focus on helping patients quit; linking the ABC approach to the System Level Measures (SLM) smoking indicator.

Smoking Cessation

ABC in Primary Care

PERFORMANCE

Over the previous year, there was a continued focus on encouraging practices in Nelson to continue to achieve and maintain the target of 90% for brief advice for their enrolled patients.

Nelson Bays Primary Health (NBPH) continued to support practices with Patient Dashboard as a practice support tool to all Medtech practices. Patient Dashboard and the Dr Info audit tool have made it a much easier and quicker task for clinicians to see at a glance when a patient requires brief advice, rather than rely on a cumbersome recall system. This has helped support most practices maintain their results.

NBPH encouraged each practice to use Dr Info more effectively and to do a weekly audit regarding brief advice to review where they are at in achieving their target. This provided instant feedback and enables them to utilise staff time more effectively.

The ABC Facilitator worked from and on behalf of, the practice when contacting patients by telephone. Practices were supported to develop a systematic approach and a sustainable plan for engaging smokers when they were in practice.

Practice support strategies included, identifying patients, prompts for clinicians at time of consultation, cold calling, provision of brief advice on behalf of the practice, facilitating smoking cessation appointments, mentoring practice staff and support for practices to develop a whole of practice plan to engage with smokers will continue. The philosophy continued to be 'every patient every time', although some practices are reporting 'push back' from patients about feeling badgered.

The ABC Smokefree Facilitator continued to foster relationships with Nelson Marlborough Health Smokefree Coordinator(s), Heart Foundation and other Community Facilitators through regular meetings to share resources, work together to support primary health care providers and to maximise coverage of ABC support, resources and opportunities. NBPH continued to participate in the Nelson Marlborough Smokefree Alliance between Nelson Marlborough Health, Marlborough Primary Health and NBPH who worked together to develop a comprehensive approach to ABC Smokefree in primary and secondary services.

A variety of education opportunities were provided/facilitated by the ABC Smokefree Facilitator. These included:

- Ongoing practice support in the use of Patient Dashboard and Dr Info to maximise the use of the in-practice support and audit tools available.

The latest Smoking Status information showed that 97.2% of the population have a smoking status recorded. Brief Advice was given to 88.1% of the total population.

MAORI HEALTH ACTIVITIES

Practices committed more resources to encourage Māori to attend practice and working with the Kaiatawhai Whanau Ora Liaison Team to make contact and offer options to stop smoking.

The latest Smoking Status information 2017 shows that 96.4% of the High Needs population had a smoking status recorded. This outcome has been incrementally increasing. High Needs population data represents Māori, Pasifika and those people residing in New Zealand Quintile 5. This information allows practices to target Māori and other priority groups to offer brief advice and smoking cessation support.

Brief Advice was given to 86.6% of the high needs population, indicating that more work is required still.

Nursing Services

Community Respiratory Service

PURPOSE To provide a community-based respiratory and chronic obstructive pulmonary disease (COPD) care and education service which includes assessment, treatment, medication advice and education in line with current best practice.

OBJECTIVE

- Provision of a culturally appropriate, integrated asthma and COPD education service to the community;
- Promotion of increased community awareness of asthma and COPD;
- Encouragement of self-management of asthma/COPD in order to improve quality of life and reduce morbidity.

NBPH supports the Nelson Asthma Society with three key objectives:

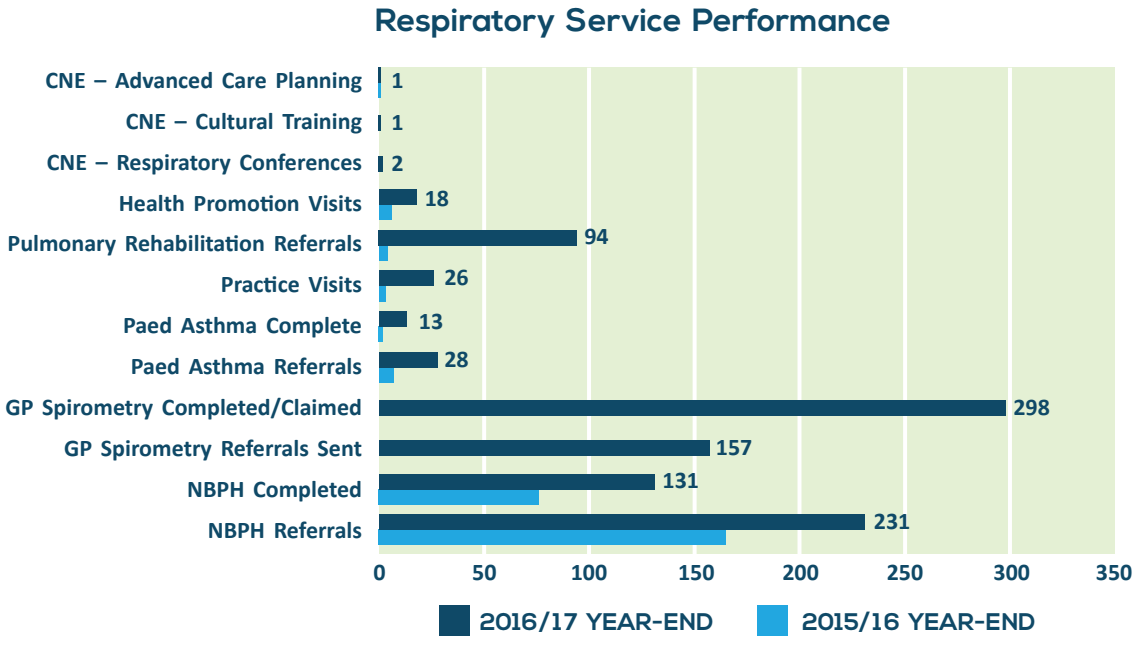
- Public relations and Health Promotion activities
- Development and coordination of community self-help groups, including COPD groups in Motueka and in Nelson
- Provision of Pulmonary Rehabilitation Programmes throughout the year

PROGRAMME OVERVIEW

The clinical service is focused on working with primary health care providers to assist people with mild, moderate and severe asthma and COPD. It includes the following:

- Assessment, treatment, medication advice and education congruent with current best practice
- Working with general practice to assist primary care staff to meet the needs of people with respiratory disease
- Education and advice on asthma and COPD and available services
- Linking clients with appropriate community-based support agencies, e.g. smoking cessation
- Facilitation services targeted at whānau/family not likely to access asthma and COPD disease services and provide them with a way of receiving them
- Post-discharge visits where required following asthma/COPD exacerbations

PERFORMANCE



Asthma Education – New Paediatric draft guidelines has been disseminated for comment which include preschool wheeze. Due to be released in Sept 2017.

DHB service – NBPH's Respiratory Nurse performed an audit of people who have been waiting on the DHB Respiratory follow up waiting list for more than 12 months. This was funded by Nelson Marlborough Health. A full report was distributed and further discussion pending in August 2017.

The aim of the project for NBPH was to identify gaps in the community respiratory service to enable people to be discharged back to their GP for managed respiratory care. The physiologist from the DHB is supported through the Nurses Peer Support Group.

Pulmonary Rehabilitation – This programme commenced April 2017 in Nelson with the first programme being very successful. The first programme had an excellent attendance rate of 81%, with the majority of participants showing a subjective improvement in their respiratory health knowledge and medication knowledge compared with prior to attending. Evidence demonstrates this improves a patients ability to self-manage their respiratory condition.

The programme had a 50:50 gender split and 92% were aged over 65 years. 93% identified themselves as New Zealand or European ethnicity with 7.7% Māori.

Some comments from the participants were:

> ***"I believe it is necessary to have these groups available so we can help ourselves to keep good health with this condition. I also believe it is necessary for us to be able to access trained knowledgeable people when necessary who can assist us and point us in the right direction."***

> ***"Loved the variety of exercises. I hope it will encourage me to carry on exercising regularly and to not be afraid to push myself"***

The next programme is underway with 26 participants and a further programme is scheduled in October-November 2017.

Spirometry Providers – A spirometry update workshop was held with 4 spirometry audits performed.

The Peer Support Group continues on a bi-monthly basis.

Health pathways and the Community Care Coordination referral forms have been updated to align with current processes.

PARTICIPANTS IDENTIFYING AS MAORI

ETHNICITY DESCRIPTOR	Q1	Q2	Q3	Q4	YTD
Māori participation/referral	10	4	4	5	23

NBPH Respiratory service are not receiving referrals for Māori or Pacific Island populations at an expected rate. There are continued discussions to support inclusion in the service.

Director of

Primary Care Nursing

PURPOSE The Regional Director of Nursing, Primary Health Care is a district wide position implemented in April 2017. This position supports the nursing strategic direction of the regions two Primary Health Organisations, Marlborough Primary Health and Nelson Bays Primary Health (NBPH) as well as the Top of the South Health Alliance, an alliance between Nelson Marlborough Health, Marlborough Primary Health and NBPH.

OBJECTIVE

- Provide clinical leadership and expertise in contemporary nursing practice
- Encourage a safe and supportive practice environment
- Implement a nursing care delivery model that supports service requirements
- Provide active nursing leadership; strategic direction; advice and support for all primary care health nurses working in the Nelson Marlborough region

PROGRAMME OVERVIEW

This position is a key driver of the nursing workforce resource which is an enabler for improving population health outcomes. Nurses work actively across key priority areas such as keeping people well and active and out of hospital. Nurses in the community support this aim through delivering health promotion, disease prevention and treatment, immunisation and screening, care coordination and navigation.

There is an expectation that nursing is part of robust and patient centred models of primary health care.

PERFORMANCE

- Relationships and lines of communication are being built up between the Director of Primary Care Nursing and local nurses
- Site visits to 60% of General Practices is complete. Nursing/general practice teams have provided feedback for change
- The first quarterly practice nurse forum has been held

District Immunisation

Facilitation Service

PURPOSE To provide effective and efficient linkages and collaborative working relationships with all service providers with an interest in immunisation and Well Child/Tamariki Ora activities across the district to increase coverage of immunisations within the population.

OBJECTIVE

- To provide up-to-date, accurate information to providers and the public about immunisations
- To ensure integrity of the cold-chain, through effective monitoring and audit
- To assist providers to develop their recall systems and immunisation quality plans
- To collaborate with Well Child/Tamariki Ora providers
- To assist with National Standard setting and consistency of implementation
- To support educators and immunisation outreach services
- To assist in workforce development especially for services that focus on improving access for disadvantaged populations (specifically Māori and Pasifika providers)
- To proactively and reactively deal with the media through an effective communication strategy

PROGRAMME OVERVIEW

Nelson Bays Primary Health (NBPH) is the contract lead for this collaborative partnership between Nelson Marlborough Health (NMH) Public Health Service and Marlborough Primary Health. Immunisation service providers maintain effective and efficient linkages with NMH and primary care services. Key to this is face-to-face contact between immunisation facilitators and medical practitioners'/practice nurses. Facilitators also maintain effective linkages with other NMH immunisation services (in particular the National Immunisation Register administrators, NMH Public Health Service, Planning and Funding, Medical Officers of Health and Outreach Immunisation Services); regional immunisation advisors (currently employed by the Immunisation Advisory Centre (IMAC) and other agencies or providers as appropriate.

continues over...

District Immunisation

Facilitation Service

PROGRAMME OVERVIEW *continued*

The Immunisation Partnership Group, in conjunction with other providers, has a strategic plan for increasing immunisation coverage in NMH region as well as sharing of information, training/ education, communication, and other areas of common interest where health gains can best be achieved through collaboration or cooperation.

ELIGIBILITY CRITERIA

The population of Nelson Bays Primary Health (NBPH) – eligible and enrolled.

... in Nelson there were a high number of decliners who are well educated and chose not to immunise their children, affecting Ministry of Health targets.

PERFORMANCE

- Influenza immunisations offered to all staff at NBPH with 75% uptake
- Provision of monthly Immunisation Newsletters
- Clinical Assessments provided
- Health provider support provided to:
  - Pharmacists, Occupational health Nurses, Public Health and General practices
  - Vaccinator Training Courses
  - Talk Immunisation Programme run throughout the year- delivered across the district
  - Website updated in Marlborough
  - National Immunisation Schedule Changes promoted

REFERRAL TARGETS (YEAR):

The National 8 month Immunisation target has been met in Marlborough but in Nelson there were a high number of decliners who are well educated and chose not to immunise their children. This affects outcome for the Ministry of Health targets.

CHALLENGES

- Our static decliner rate and the Ministry of Health target for 95%
- Practices are reporting that conversations about vaccination with people who are declining are becoming more difficult therefore the challenge is to support health professionals to have these challenging conversations
- To locate and "find" decliners and to implement a strategy that will provide opportunity to have discussions regarding: immunisation. Inter-agency privacy limitations impact on the ability to locate transient population
- National health promotion strategies for vaccine preventable diseases

MAORI HEALTH ACTIVITIES

- A recent meeting was held with Whākatū Marae to support their influenza clinic
- Liaison with Te Piki Oranga and training support provided for their nurses
- Engagement with Kaiatawhai service to strategize on how to link the clients into practice or provide community services to ensure timely immunisation across the hard to reach population

Lactation Service

PURPOSE The Breastfeeding Coordination Contract delivers on a range of actions from the Nelson Marlborough Breastfeeding Action Plan.

Nelson Bays Primary Health (NBPH) provides Lactation Consultant Services to Nelson Marlborough Health and the Community to support referred breastfeeding mums who have breastfeeding problems and need specialist input.

OBJECTIVE

- To ensure that women and health professionals have the confidence, knowledge, skills and attitudes to protect, promote, support and enable establishment and continuations of breastfeeding in line with national standards and legislation.
- To contribute to an increase in the rates of breastfeeding in the population at the discharge from the maternity unit, at 6 weeks postnatal, at 3 months and at 6 months.

PROGRAMME OVERVIEW

Nelson Bays Primary Health Organisation has a 0.5FTE Lactation Consultant position to provide all clinical services to breastfeeding mothers across both primary and secondary care settings as well as offering educational and lactation advice and support to all health professionals in the hospital and community.

2016/17 has been a busy year with 267 referrals to the Lactation service

Lactation Service

PERFORMANCE

2016/17 has been a busy year with 267 referrals to the Lactation service from across primary and secondary care. Many of these referrals being of high acuity and requiring sustained input over a period of weeks and occasional months. This involves a high number of follow up phone calls (869 in total across clients, referrers and other health professionals) to support clients towards a positive breastfeeding outcome.

Of those mothers seen this year, 66% were exclusively breastfeeding, 27% were partially breastfeeding and only 1% of babies were artificially feeding at their time of discharge from the service, which reflects the NBPH's Lactation Consultant's commitment to supporting women and persevering when there is complexity.

This role is contracted to service the entire Nelson region in both inpatient wards (Maternity, SCBU, Paediatrics and outlying medical, surgical wards or ICU) and community agencies (Midwifery, Well Child/Tamariki Ora Services, GPs, Practice Nurses and other support agencies who have contact with breastfeeding women). Consequently, the Lactation Consultant is often called upon to meet acute and urgent cares. This can be challenging, as in the secondary care setting, where readmissions in particular of mothers and babies are often of an acute nature requiring urgent input, to facilitate a feeding plan as early as possible and thereby minimise their overall hospital stay is often outside of normal hours of work.

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

SERVICE REQUIREMENTS	DELIVERY	PROVIDED
One to One Consultations	220-240 per annum clients seen with an average of 3 contacts per client face to face and by phone follow up	267 individual
Consultancy Advice to Health Professionals	100 or more per annum	200 minimum
Breastfeeding Education Sessions to Health Professionals	Approx 10 per annum	15 sessions minimum

PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC

During the last year, 5% of clients referred to the service identified as Māori and 2% as Pacific Island.

Telephone Nurse Triage Service

HML

PURPOSE To provide quality telephone advice and assistance by Registered Nurses for the Nelson Bays population during the hours that participating General Practitioners or other providers are unavailable and have diverted their telephones to HML.

OBJECTIVE

- Provision of quality telephone advice and assistance by Registered Nurses for the Nelson Bays population.
- Provision of quality telephone advice and assistance to patients during hours that participating General Practices or other providers are unavailable and have diverted their telephones to HML.
- Reduction of on-call commitments for participating providers.
- Provision of information and recommendations to inform development of after-hours primary health care in the Nelson/Tasman region.

PROGRAMME OVERVIEW

Registered nurse telephone triage is provided, followed by referral as appropriate to other providers on a 24/7 basis, including public holidays. HML provides:

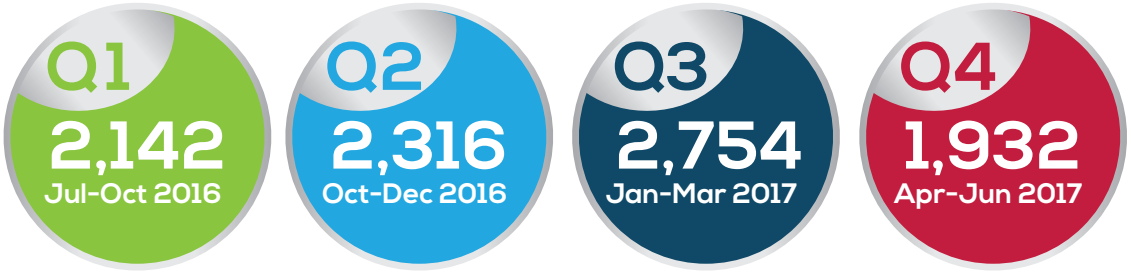
- Customised triage protocols by practice as required;
- Phones answered in the practice name to preserve provider relationships with their patients;
- Coverage for practice phones when the practice is closed;
- Emergency practice reception (when phone lines are cut or a natural disaster occurs).

Telephone Nurse Triage Service

HML

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

CALL VOLUMES FOR LAST 4 QUARTERS:



	2016			2017		
Call Analysis	**Q3 Jan-Mar**	**Q4 Apr-Jun**	**Q1 Jul-Sep**	**Q2 Oct-Dec**	**Q3 Jan-Mar**	**Q4 Apr-Jun**
Total Calls	2,621	2,058	2,142	2,316	2,754	1,932
Handover to on-call GP	475	391	281	402	360	271
Handover to after-hours primary care	167	102	83	102	121	152
Handover to emergency department	61	50	35	43	348	28
Handover to ambulance	71	65	60	67	76	72
Handover to non-health service	40	31	30	43	29	21
Other outcomes, exercise self-care & contact GP next day	300	229	291	353	325	262
Number of admin/practice information calls	1,507	1,190	1,362	1,306	1,495	1,126

NBPH have recently met with HML around the current model and number of administrative calls noted within their reports, as these represent over 58% of the total calls. A reduced cost within the contract has been agreed for the next financial year with expected further reviews of the current model and options available over this time.

Health Promotion

Health Promotion

Overview

PURPOSE The Nelson Bays population is healthy and actively engaged in staying well

PROGRAMME OVERVIEW

Health Promotion is the process of enabling people to increase control over, and to improve, their health. Health Promotion is a continuum that works in partnership with General Practice and Public Health Services to ensure healthy individuals, healthy communities and healthy environments.

Nelson Bays Primary Health (NBPH) Health Promotion supports individuals to restore health by:

- Empowering those 'with' or 'at risk of' a long term condition such as Obesity, Pre-Diabetes, Type 2 Diabetes, Osteoarthritis or a Heart Condition
- Focusing on health literacy so information is understandable
- Addressing beliefs, behaviours and building self-management skills

THE BELOW IS A SUMMARY OF PROGRAMMES THE HEALTH PROMOTION TEAM PROVIDE:

NBPH HEALTH PROMOTION SERVICE	OUTCOMES EXPECTED	PARTNERSHIPS IN DELIVERY
Community Cardiac Rehabilitation – Healthy Hearts	Build confidence and knowledge to reduce anxieties associated with heart conditions and improve health outcomes	NBPH Health Promotion team, DHB Cardiology team, Heart Foundation and participants
Community Diabetes Education - Awareness promotions - Reversing Pre-Diabetes - Living with Type 2 Diabetes	Dispelling myths, raise awareness of signs and symptoms, build confidence and knowledge to reduce disease progression	NBPH Health Promotion team, Diabetes Nurse Specialists at Nelson Marlborough Health, General Practice and Community Organisations
Community Nutrition Service - Primary Care Dietitians - Toddler Better Health	Build confidence and knowledge to make healthy food and drink choices	NBPH Health Promotion team, General Practice, Public Health, Māori Health Organisations, Community providers (e.g. Sport Tasman, YMCA, Play Centres)
Falls Prevention - Fracture Liaison Service - Upright & Able community education	Support osteoporosis prevention and identification in our older population to reduce falls injuries (in particular fractures) Build knowledge about falls hazards then facilitate strength & balance exercises participation	NBPH Health Promotion team, General Practice, Allied Health, Pharmacists, Optometrists, Community Exercise providers
Green Prescription	Build confidence and knowledge using behaviour change techniques to make healthier choices (food and activity)	NBPH Health Promotion team, General Practice, Community Organisations e.g. Aquatic facilities
The Joint Programme - Osteoarthritis self-management	Build confidence and knowledge to manage pain then facilitate participation in regular physical activity to improve quality of life	NBPH Health Promotion team, Rheumatology Service, Pain Service and Community providers

The focus for Health Promotion in Nelson Bays Primary Health is on the Individual, screening, early diagnosis, information and self-management support to slow-down disease progression.

THE BELOW IS A SUMMARY OF SERVICES THE HEALTH PROMOTION TEAM ARE INVOLVED IN:

NBPH HEALTH PROMOTION SERVICE	OUTCOMES EXPECTED	PARTNERSHIPS IN DELIVERY
Contestable funding for community organisations – Community Initiative	Financially support new Health Promotion initiatives within the community, on successful application. Community Initiative grants of $1,000 each were awarded to: • NZ Association of Psycho-therapists Te Tau Ihu Branch • Free Church of Tonga • Victory Boxing Charitable Trust • Te Piki Oranga	Community organisations – in partnership with NBPH health promotion team
Contestable funding for community organisations – Workforce Development	Financially support community or volunteer organisations to undertake health promotion upskilling, on successful application. Workforce Development grants of up to $500 each were awarded to: • Life Linc Nelson Inc • Alzheimers Society Nelson Inc • Postnatal Support Network Nelson • The Male Room	Community organisations – in partnership with NBPH health promotion team
Community Care Coordination	Electronic single referral service for community health options	Primary, Secondary and Community health providers
Interpreter and Translation Service	Former refugees settled in the Nelson region have health information in their own language. General Practice has access to telephone, video or face to face interpreters. Over 1,000 Interpreter sessions were funded this year by NBPH.	NBPH in partnership with Red Cross refugee services and Nelson Marlborough Health Interpreters
Refugee Healthy Living programme	Build confidence and knowledge in former refugee families to make healthy choices (food & physical activity)	Red Cross Refugee Cultural Workers – in partnership with NBPH Health Promotion Team
Safe at the Top / Clued Up Kids	Primary school aged children informed and aware of keeping safe – reduced ED presentations from avoidable injuries	Partnership initiative with multi agencies (e.g. ACC, DHB, Council, Fire, Police, Ambulance, NGO's, community & volunteer groups)

Community Care Coordination – CCC

PURPOSE To provide a single electronic referral point and clinical triage opportunity for referrals requiring a community health service

OBJECTIVE

- To simplify the referral process to one or more community services using one system, saving time and duplication of information for the referrer and the referee
- To support general practice by listing the options of health care services available that might best suit their patient's need
- To ensure all services involved with a patient are aware of each other's existence and role
- To ensure the patient receives the right service at the right time and that the patient is at the centre of the health care delivery
- To connect providers across primary and secondary based services though a single entry point
- To support e-referrals to a local community service (i.e. not loaded onto the national ERMS system)

PROGRAMME OVERVIEW

- CCC is based at Support Works in Richmond but receives and administers referrals from across the Nelson Marlborough district. NBPH fund 1FTE for administration staff and NMH fund the clinician. The CCC database was developed and is now maintained by HSS.
- Referrals come to the single point and are viewed by the clinician. Any relevant missing data is added, the details are entered into the database and then forwarded onto the service requested. Often this requires the CCC staff phoning the referrer to check or clarify details.

PERFORMANCE

REFERRALS RECEIVED

Total number of referrals received region wide	**11,838**
Referrals coming from a Marlborough service	1,582
Referrals coming directly from a Marlborough GP service	785

MOST FREQUENTLY REQUESTED SERVICES WERE:

Allied Health	3,514
District Nursing	3,150
Primary Care Service	2,664
Support Works	2,583
Meals on Wheels	225

N.B. More than one service can be selected on a referral

MAORI HEALTH ACTIVITIES

The CCC web-based portal **https://ecares.bewell.org.nz/** allows all community providers access to this service. This includes all Māori providers. During this reporting period Te Piki Oranga made 25 referrals using the CCC web-portal.

Community Cardiac Rehabilitation

Healthy Hearts

PURPOSE To provide community-based Cardiac Rehabilitation support for people with established cardiovascular disease (and their family/whanau) following a recent cardiac intervention, or cardiac-related hospital admission.

OBJECTIVE

To promote the best physical, psychological and social conditions, so that patients with chronic or post-acute cardiovascular disease may, by their own efforts, preserve or resume optimal functioning in society and, through improved health behaviours, slow or reverse progression of disease. *New Zealand Guidelines Group Cardiac Rehabilitation Guideline (2002).*

PROGRAMME OVERVIEW

Nelson Bays Primary Health (NBPH) delivers a community-based Cardiac Rehabilitation & self-management programme in partnership with the cardiology team at Nelson Marlborough Health. Referral is sent on discharge from hospital or via a GP referral. Two delivery options are available to those referred:

- **Healthy Hearts** - a one-off 6 hour session held in the community. Sessions can be split into two half days if preferred – usually offered to those following a By-pass graft (CABG)
- **Heart Guide Aotearoa** - home-based work-book option with telephone support and follow up.
- All patients are asked to evaluate the session on completion so co-design influences all developments.
- All patients receive postal follow-up for a 12 month period.
- Quality improvements are informed following a PDSA (Plan, Do, Study, Act) process.
- Sessions are peer-reviewed and co-presented by the Cardiac Nurse Specialist team. Victory Pharmacy have kindly volunteered their Community Pharmacist to deliver relevant medication information at each session.

PERFORMANCE

11 X HEALTHY HEARTS SESSIONS DELIVERED THIS YEAR:

88 Patients attended

152 Patients referred

HGA	Uptake Rate	Male	Female	Aged 65 or Under	Māori	Asian	Family Whanau Attended	TOTAL Participants Attended
3	91/152 = 60%	70	18	34	4	2	45	133 Includes patient & family

PERSONAL SUCCESS FEEDBACK:

> ***"I really needed the push to do something about my health and this session gave me the info to look at where I go to from here"***

Community Cardiac Rehabilitation

Healthy Hearts

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Session Evaluation shows:

- **99% of participants reported having improved cardiovascular disease knowledge**
- **98% of participants reported they feel more confident to manage their condition**

CHALLENGES

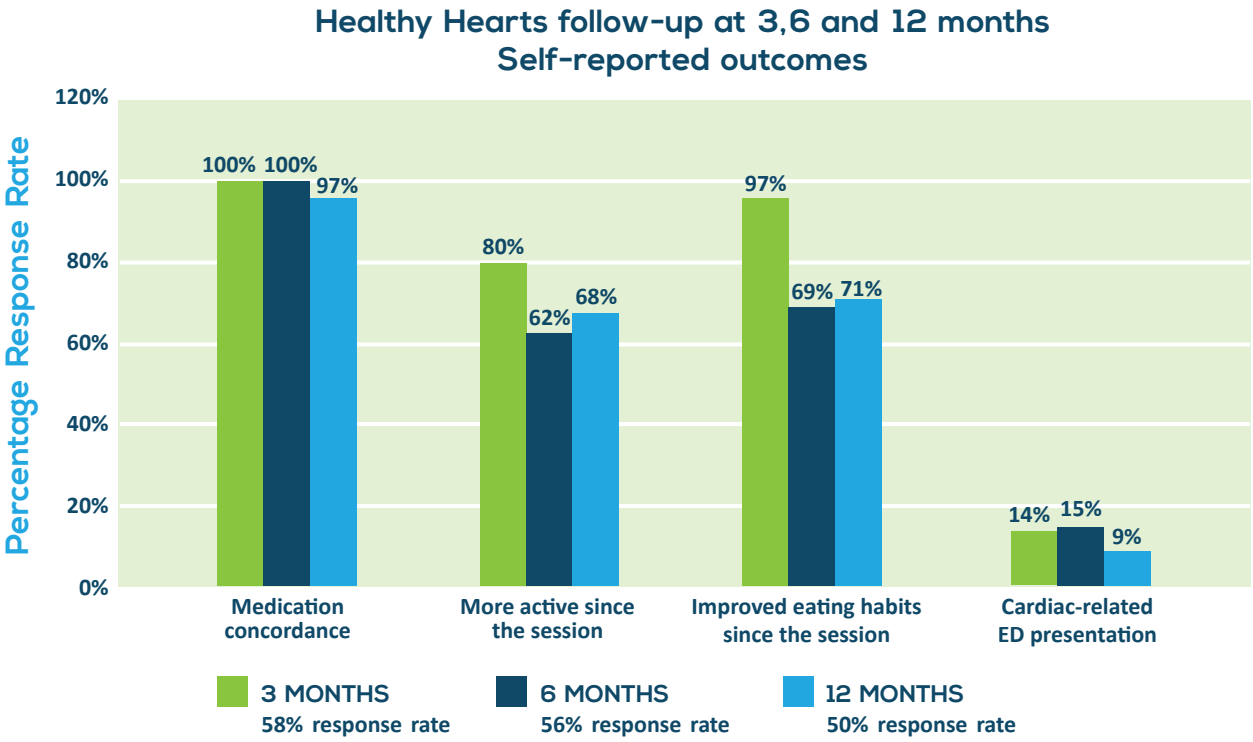
Referral numbers have **declined by 29%** this year down to 152. However this could be seen as a positive (eg. less admissions).

SUCCESSES:

- Cardiac rehabilitation uptake rate has increased from 57% (last year) to 60% (this year) which **exceeds the National average**
- Medication compliance **exceeds the national average**
- Repeat Emergency Department Presentations for this high risk group are **below national averages**

In summary – all very good (outstanding) outcomes

IS ANYONE BETTER OFF?



MAORI HEALTH ACTIVITIES

- Number attended: 4
- Currently working with Te Piki Oranga staff in Motueka to plan culturally appropriate information on heart health for Māori.
- Coordinator involved in a Primary Care-based Whakakotahi project, "Living longer, feeling better after a heart event" to increase medication uptake rates (Atlas of Healthcare shows that 38%-46% do not collect medications after a major cardiac event with high rates among Māori).

Community Diabetes Education

Type 2 and Pre-diabetes

From right to left. Lindy Rule (patient) with Bee Williamson (Heart and Diabetes Coordinator) and Marc Davidsen (Green Prescription Team Leader) holding a model of clogged arteries (blood vessels).

PURPOSE To provide community information sessions for people either at risk of, or with type 2 diabetes, and their family/whanau.

OBJECTIVE

- To promote awareness, wellness and confidence to self-manage type 2 diabetes and reduce the risk of complications
- To prevent or delay the onset of type 2 diabetes

PROGRAMME OVERVIEW

- **"Living well with type 2 diabetes"** is a one-off 6 hour self-management session delivered at various locations in the community. Most sessions are held on a Saturday.
- **"Reversing Pre-diabetes"** is a one-off 2.5 hour session held in the community or at a local General Practice. Sessions are delivered afterhours in partnership with the Green Prescription staff and General Practice.
- All patients receive postal follow-up for a 12 month period to monitor progress and drive co-design enhancements.
- Quality improvements are informed following a PDSA (Plan, Do, Study, Act) process.
- Sessions are peer-reviewed by the NMH Diabetes Nurse Specialist team.

Community Diabetes Education

Type 2 and Pre-diabetes

PERFORMANCE

Paitents Attended **52** Newly diagnosed

PERSONAL SUCCESS FEEDBACK:

"I have lost 25kgs - down from 125 to 100kgs. Best thing I have done to learn more about my diabetes. Before it was in one ear and out the other"

8 X LIVING WELL WITH TYPE 2 DIABETES SESSIONS DELIVERED THIS YEAR:

Male	Female	Aged 65 or Under	Māori	NZE	Family Whanau Attended	TOTAL Participants Attended
23	29	25	4	48	17	69 Includes patient & family

DIABETES AWARENESS TALKS:

9 sessions were delivered throughout the year to community organisations, including a session to 30 senior nursing students at Nelson Marlborough Institute of Technology.

Paitents Attended **82**

12 X REVERSING PREDIABETES SESSIONS DELIVERED THIS YEAR:

Male	Female	Aged 65 or Under	Māori	Pacific	Asian	NZE	Family Whanau Attended	TOTAL Participants Attended
23	59	34	2	2	5	73	29	111 Includes patient & family

Nelson Bays Primary Health staff promoting Diabetes week.

100% of participants reported having improved their knowledge about diabetes

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

At the end of each session an evaluation is completed. Over a 12 month period evaluation results show:

- **100% of participants reported having improved their knowledge about diabetes**
- **97% of participants reported having improved confidence to manage their diabetes**

CHALLENGES:

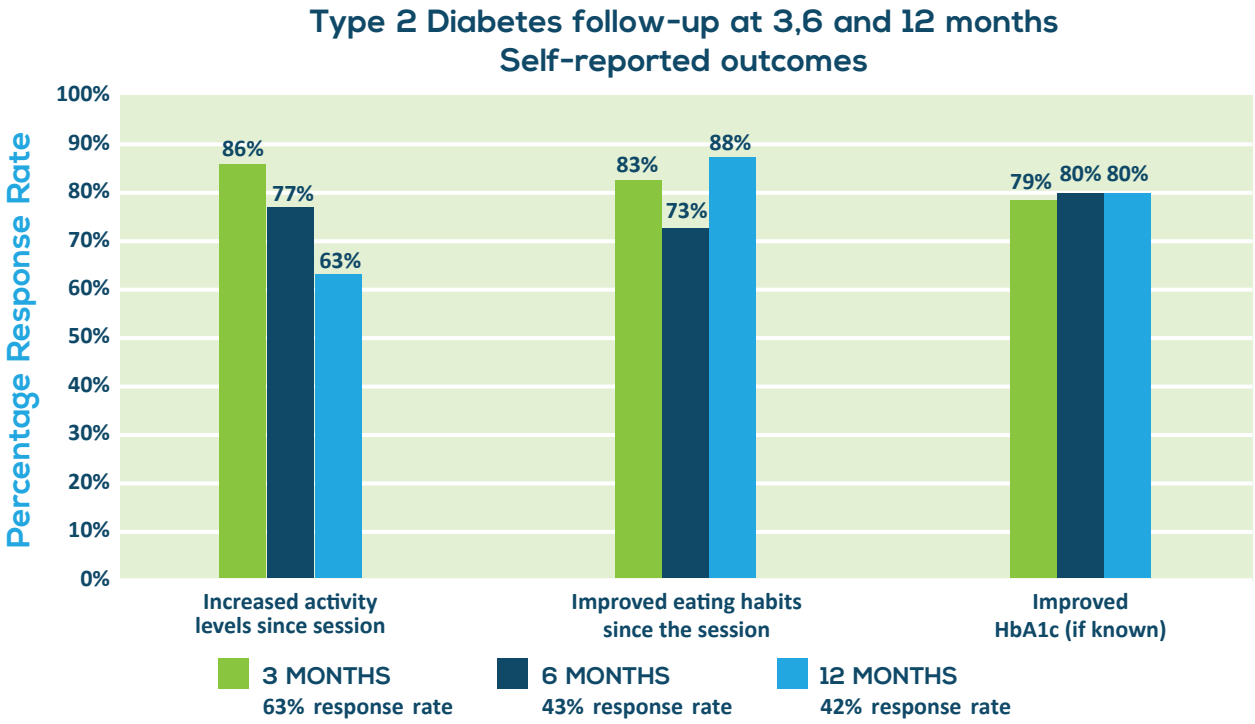
Patients being referred due to a pre-diabetes diagnosis have reduced this year (from 220 last year down to 82 this year). This could be related to heart & diabetes checks no longer being a Ministry of Health target.

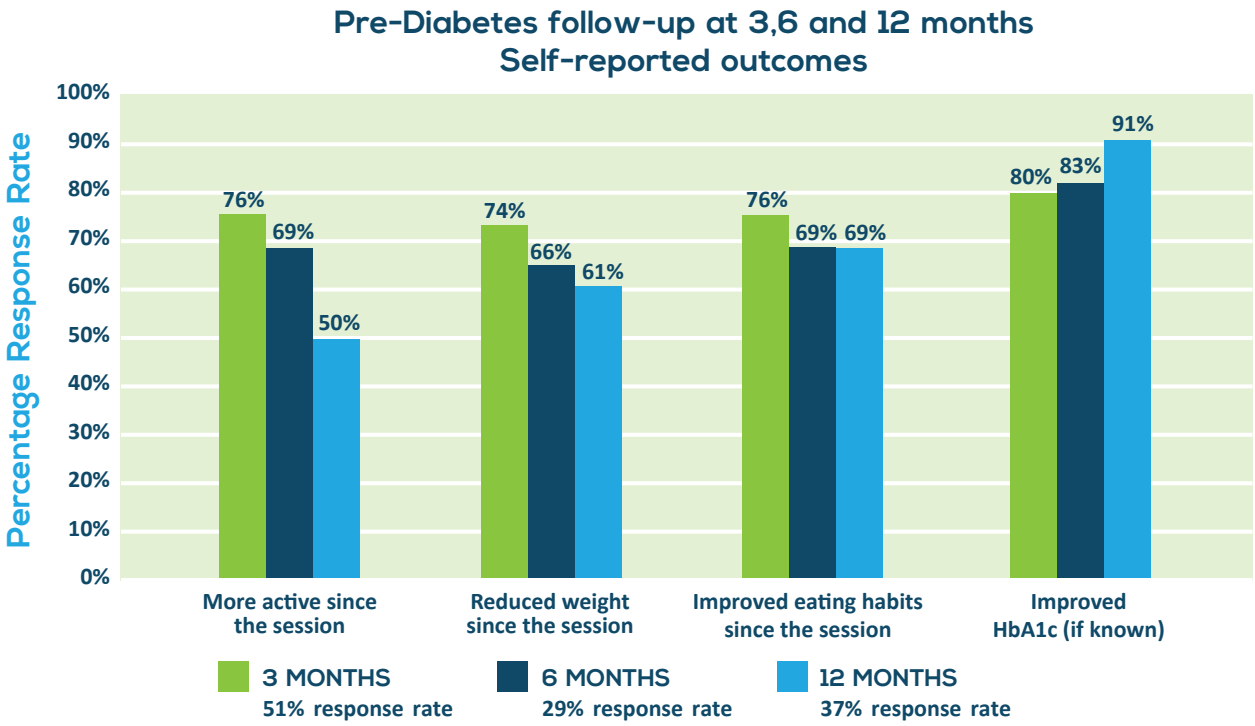
A 12 month follow-up of participants who had completed a "Living well with type 2 diabetes" session showed...

Community Diabetes Education

Type 2 and Pre-diabetes

IS ANYONE BETTER OFF?





MAORI HEALTH ACTIVITIES

- Six Māori have attended a diabetes education session.
- Working with Te Piki Oranga staff in Motueka to plan simple, understandable and informative sessions on Diabetes for Māori.

Falls Prevention

Community Falls Prevention Upright and Able

PURPOSE Reduce the incidence and impact of falls among the 65+ age group.

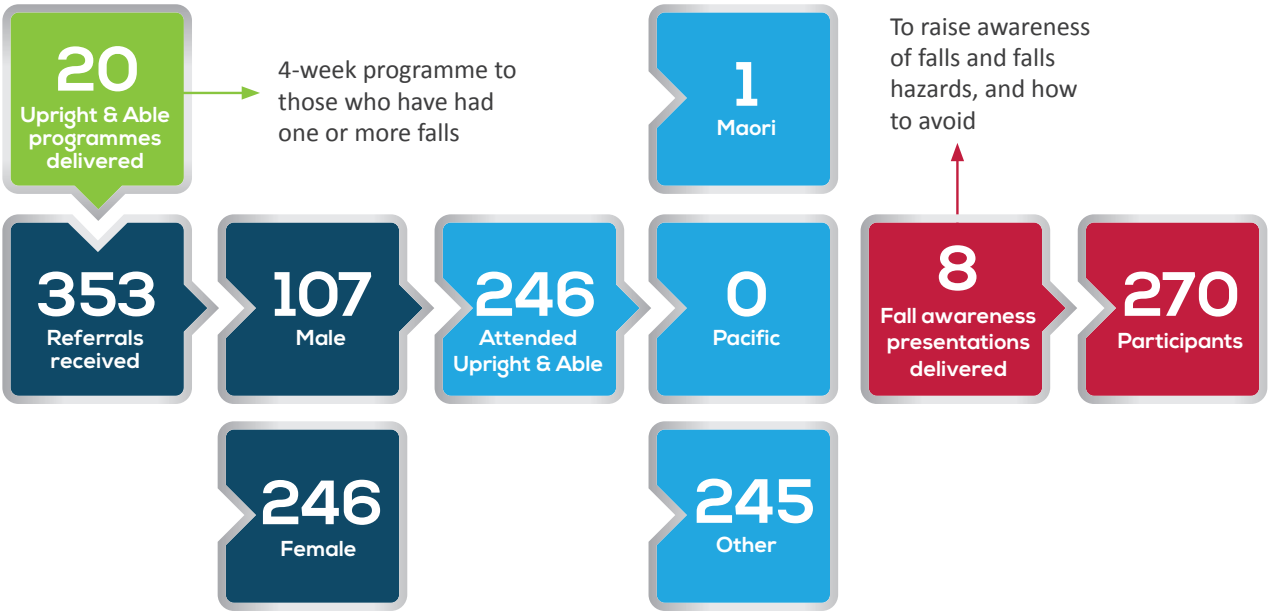
OBJECTIVE

Deliver a multi-week older adult self-management programme that built knowledge and confidence, reducing fear to be independently active and practicing daily strength & balance exercises

PROGRAMME OVERVIEW

- Upright & Able is a 4-week community falls prevention education programme which NBPH developed in 2009 and has been delivering ever since. The education component consists of topics such as:- awareness of falls hazards and what to do about them, importance of calcium and Vit D, footwear and feet-care, importance of medication reviews and keeping physically active. It taught people strength & balance exercises that they can do at home and introduced them to community exercise classes that have been assessed by Nelson Bays Primary Health.
- On 30th June 2017 the contract to deliver this programme ceased and ACC are introducing a different model for community falls prevention nationally.

PERFORMANCE



Falls Prevention

Community Falls Prevention Upright and Able

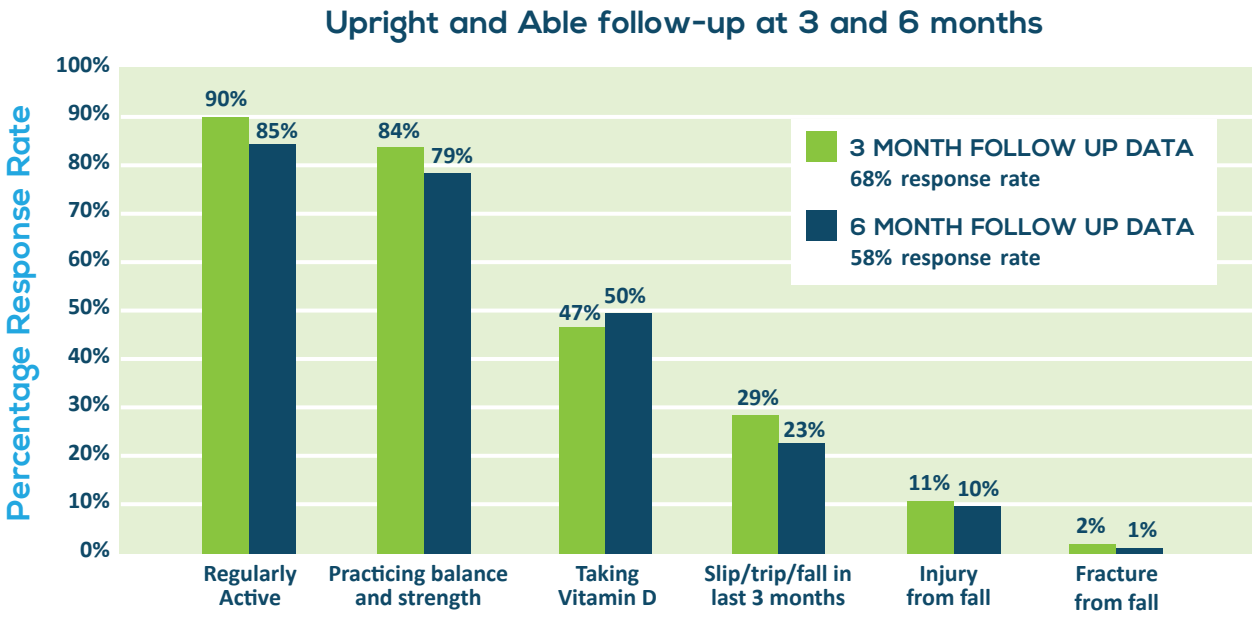
K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

At the completion of Upright and Able 4-week programme, each participant is asked to complete an evaluation. Some participants take the evaluation form home to complete and post back (stamped envelope provided). Reasons for this include: too tired after programme, transport is waiting etc.

ANAYLSIS OF THE 12 MONTHS RESULTS (FROM A RESPONSE RATE OF 82%)

Percentage who reported they are now more aware of how to prevent a fall	99%	Percentage on Vitamin D already	38%
Percentage who reported they intend to get more active	84%	Percentage who intend to speak to their Doctor about Vitamin D	77%
Percentage who reported the balance and strength exercises will help them	96%	Percentage who rated Upright and Able 8-10 out of 10	95%

IS ANYONE BETTER OFF?



MAORI HEALTH ACTIVITIES

- Falls Awareness presentation provided in partnership with 'The Shed' in Motueka.
- Working in partnership with Te Piki Oranga to establish a falls prevention programme in Motueka, based at Te Āwhina Marae.
  - Number of Māori referred to Upright and Able: 5
  - Number of Māori attending Upright and Able: 1
  - Two Māori men supported to join an aqua based falls prevention programme held twice a week in Richmond. They have attended every week to date.

Falls Prevention

Fracture Liaison Service

PURPOSE Falls are the most common and costly cause of injury and hospital admissions in people over the age of 65 years.

The purpose of this contract is to facilitate an effective falls and fracture system, a seamless referral pathway, and a joined up approach to falls. Nelson Bays Primary Health (NBPH) has been working successfully towards this for several years in partnership with ACC under various contracts.

OBJECTIVE

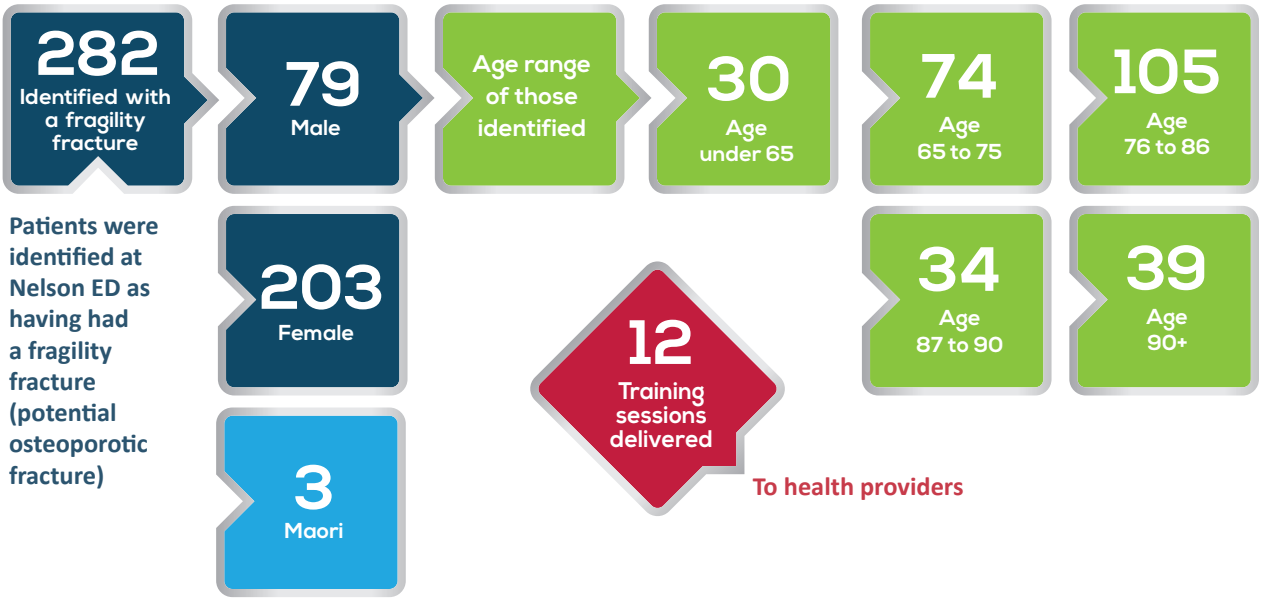
Overall objective is to reduce all fractures in particular hip fractures in older adults.

PROGRAMME OVERVIEW

The NBPH Fracture Liaison service (FLS) is a sustainable model that builds primary care pathways, and supports General Practice to identify, treat and manage osteoporotic fractures and refer on to appropriate services e.g. falls prevention. The service will also build and support early identification of osteoporosis to prevent fragility fractures and provide workforce development to upskill where needed.

PERFORMANCE

(NB: this contract has not been fully functional for 12 months)



MAORI HEALTH ACTIVITIES

A review of data available re: rate of Māori hip fractures shown in the Nelson region, 3 clients identified as Māori as having potential osteoporotic fracture.

A University of Otago review of Nelson Marlborough Māori Health Profile identified in 2011-2013 indicated 1 hip fracture per year for our Māori population over 65 years compared to 143 per year for non-Māori.

Community Nutrition Service

Primary Care Dietitians

PURPOSE To support individuals and whanau to make culturally appropriate, safe and nutritious food choices to prevent and manage long term conditions and other nutritional related conditions.

OBJECTIVE

- To support *Healthy people, healthy communities* through group self-management education and individualised one-to-one appointments
- To support *Healthy and informed workforce* through workforce development training and up-skilling, consultancy services, partnerships across the primary and secondary sector and case management support to general practice

PROGRAMME OVERVIEW

There are four components to the service:

1. Workforce development and train-the-trainer nutrition education for Primary Care health workers
2. Group self-management education for prevention and management of long term conditions including Toddler Better Health Programme, Living with Type 2 Diabetes, Healthy Hearts and Pulmonary Rehabilitation.
3. One-to-One Primary Care Dietitian appointments, where possible, within the General Practice, or Primary Health Care Provider environment.
4. Consultancy services for NBPH colleagues, Primary and Public Health workforce(s), Not-for-profit health promotion organisations.

PERFORMANCE

DESCRIPTOR	TARGET	JULY 2016 to JUNE 2017
PRIMARY CARE DIETITIAN 1:1 consultations		
Total Referrals Booked	**800**	**942**
- Total patients seen		802
- Adults Attended		680
- Adults DNA		121
- Paediatric Attended		123
- Paediatric DNA		22
Self-Management Education		
Total SME (Group) Education	**20**	**26 Groups**, 321 *people*
- Type 2 Diabetes		**7 Groups,** 55 *people*
- Healthy Hearts		**10 Groups,** 124 *people*
- Other:		**6 Groups,** 110 *people*
- Toddler Better Health	**4**	**3 Groups**, 15 *families*
Workforce Development		
Number of education sessions	**8**	**10 sessions,** 127 *workers*

LIVING WELL WITH TYPE 2 DIABETES:

Session Evaluation shows:

- **100% of participants improved their diabetes knowledge**
- **97% of participants improved their confidence to manage their condition**
- **86% of participants rate the session at least 8/10**

HEALTHY HEARTS:

Session Evaluation shows:

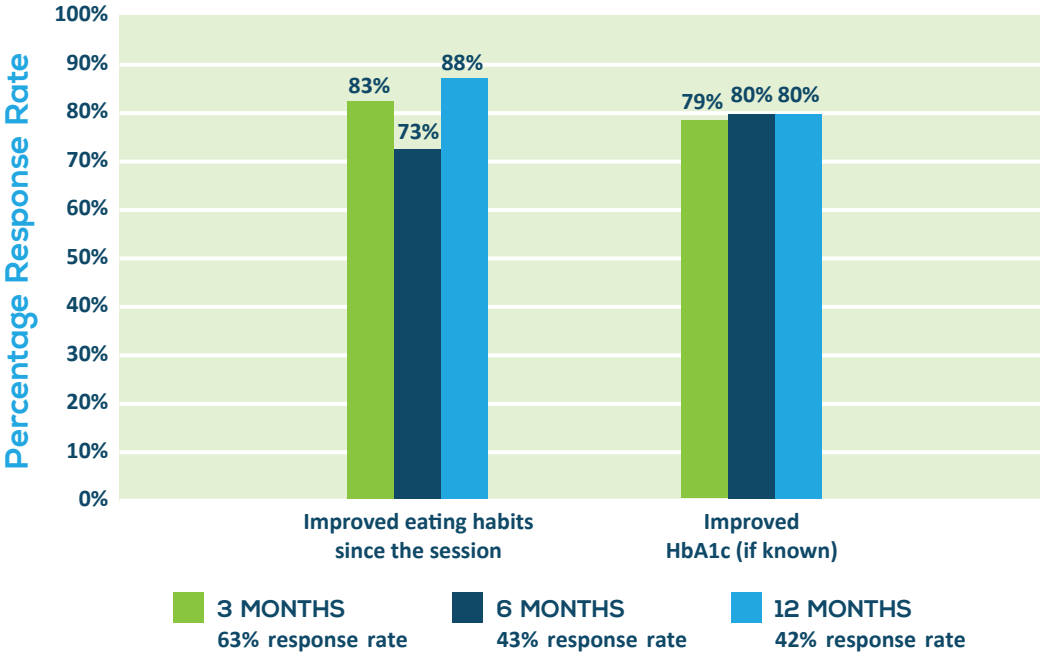
- **99% of participants improved their heart disease knowledge**
- **98% of participants improved their confidence to manage their condition**
- **96% of participants rate the session at least 8/10**

IS ANYONE BETTER OFF?

Type 2 Diabetes Programme participants and Healthy Heart participants were followed up via postal questionnaire at the end of the programme and 3, 6 and 12 months post programme.

Over 70% of both group respondents had sustained an improvement in their eating habits in the 12 months since attending the programme.

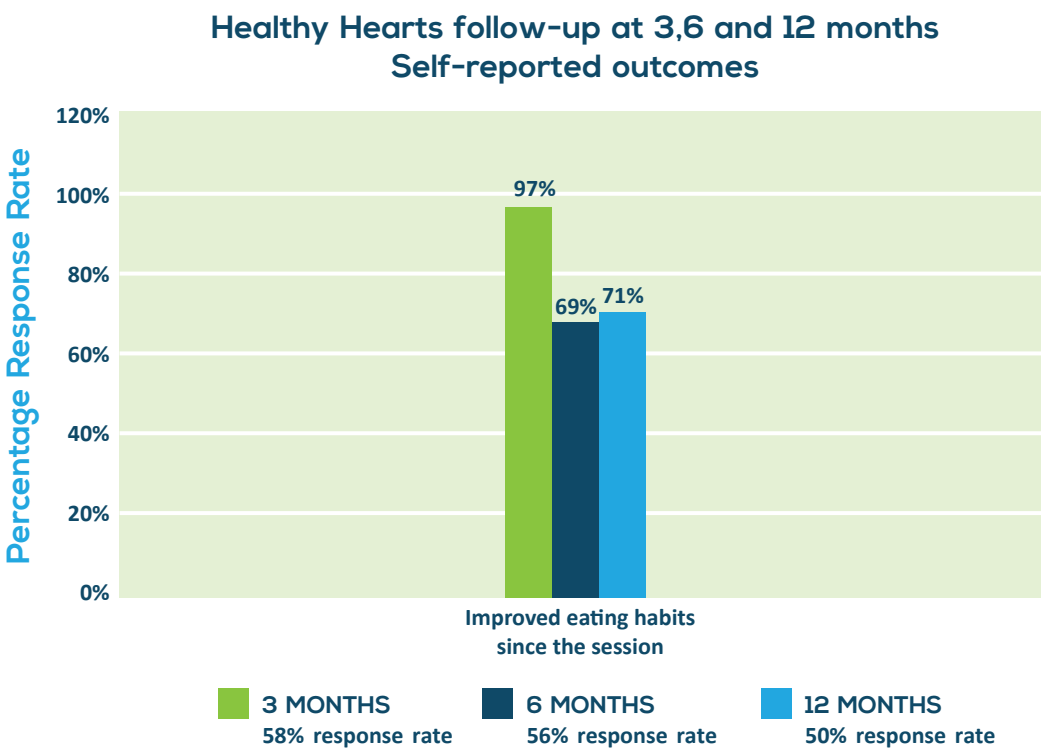
Type 2 Diabetes follow-up at 3,6 and 12 months Self-reported outcomes



Community Nutrition Service

Primary Care Dietitians

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS



MAORI (AND OTHER VULNERABLE GROUPS HEALTH ACTIVITIES

- 11% Referrals Māori; 2% Pacific and 3% Asian – totalling 16%
- 6% Māori attended Living well with type 2 diabetes; 3% Māori attended Healthy Hearts
- Monthly clinic provided at Te Piki Oranga, Motueka, since January 2017
- Opportunistic discussions with Te Piki Oranga workers on a range of nutrition topics including supermarket shopping, label reading and health star rating.
- Train the trainer provided for Red Cross Cultural Workers on healthy food choices and healthy lifestyles due to reports of significant weight gain and poor health due to food habits and choices adopted within New Zealand. The healthy lifestyles programme supported families to make a number of significant changes, including the following changes:
  - Reduced amount of juice purchased – water is consumed as an alternative.
  - Children' lunchboxes have improved with decreased quantities of lollies and biscuits
  - People are trying to reduce their consumption of white rice, slowly accepting brown rice is a healthier option and also increasing consumption of vegetables
  - Decreased intake of takeaway and high energy food and drinks

Community Nutrition Service

Toddler Better Health Programme

PURPOSE

To support *Healthy people and healthy communities* and the Ministry of Health Raising Healthy Kids target through providing an evidence based, family-centred, healthy eating and activity programme for families of children 2 – 4 years old.

PROGRAMME OVERVIEW

The Toddler Better Health Programme (TBHP) is an evidence-based programme for all families with pre-school aged children using a whanau ora (family-based) approach to encourage healthy habits and behaviours. The programme is run in partnership with Sport Tasman, with their valuable experience and expertise in activity for families.

Referral to the programme is from the Public Health Nurses and the B4 School checks, from Primary and Secondary health services, as well as self-referral. Toddler Better health is a multi-week programme running over 8-weeks and every session includes:

- Active play: A structured activity session where parents/caregivers and children are active together playing with common household items
- Snack time: An opportunity for role-modelling, consistency and trying a new raw fruit and vegetable each week.
- Discussion/Creative play: The Dietitian leads a parental discussion on a range of behaviour change topics, including the food groups, strategies to address fussy eating behaviours and healthy activity.

PERFORMANCE

Funding and contracts for this service arrived after the first quarter had started, so only 3 out of 4 programmes were provided.

3 Programmes delivered

20 Family referrals received

15 Families completed

4 Maori/Pacific attended

4 Other/Asian attended

7 NZ/European attended

Programmes were of 8 weeks duration

32 participants within those 15 families. 75% completed.

Community Nutrition Service

Toddler Better Health Programme

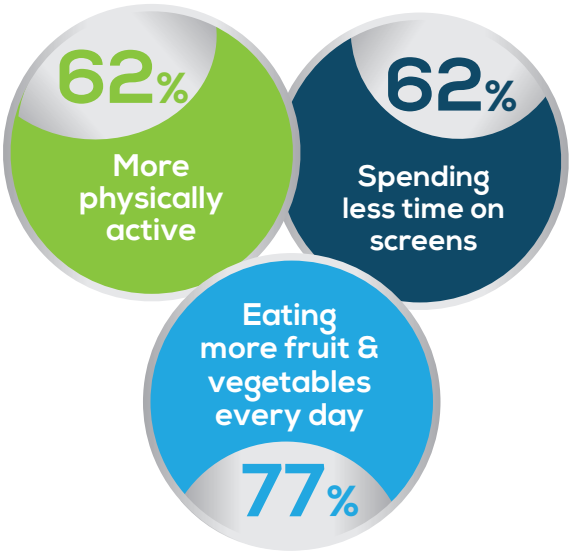
K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Programme/Participant Feedback

- **"Thank you very much to the team as I now have more of an understanding about a child's needs, especially their food."**
- **"We loved the programme, it has been very well run, very informative and fun. We will recommend to others"**
- **"Absolutely recommend to any parent!"**
- **"We both enjoyed the programme and have learnt a lot about being active and eating healthy foods."**
- **"It was a great programme for getting us thinking about what we eat, rather than just going with the same old same old all the time."**

IS ANYONE BETTER OFF?

After completing the Toddler Better Health Programme, parents reported...



PARTICIPANT FEEDBACK

- "I would never have tried giving raw cauliflower, but now he regularly has this for afternoon tea at kindy. I would recommend the programme to any parent".
- "My child tries new things now and nibbles them if not sure. I have changed my diet completely."
- "Toddler Better Health definitely helped me understand portion sizes"
- "We're out on bikes and walking to more activities. She loves vegetables including capsicum since the programme. I'm listening to the children more when they say they have had enough or want more so they understand to listen to their body. Trying to model the eating behaviours I expect. It was a great programme to get us thinking about what we eat rather than just going with the same old foods all the time."

MAORI (AND OTHER VULNERABLE GROUPS HEALTH ACTIVITIES

- 27% who completed the programme were Māori
- 27% Asian (former refugees), totalling 54% of programme attendees were vulnerable populations.

Green Prescription

PURPOSE A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management. It is designed to build confidence and knowledge so people are self-motivated to make healthier choices to improve their health outcomes.

OBJECTIVE

The core objectives of the Green Prescription (GRx) programme are to:

- Increase levels of physical activity in the adult population, building on the national physical activity guidelines
- Increase knowledge and understanding of healthy food choices using evidenced-based information and resources
- Provide an effective and evidenced-based programme that build self-management skills
- Monitor and evaluate to prove outcomes

PROGRAMME OVERVIEW

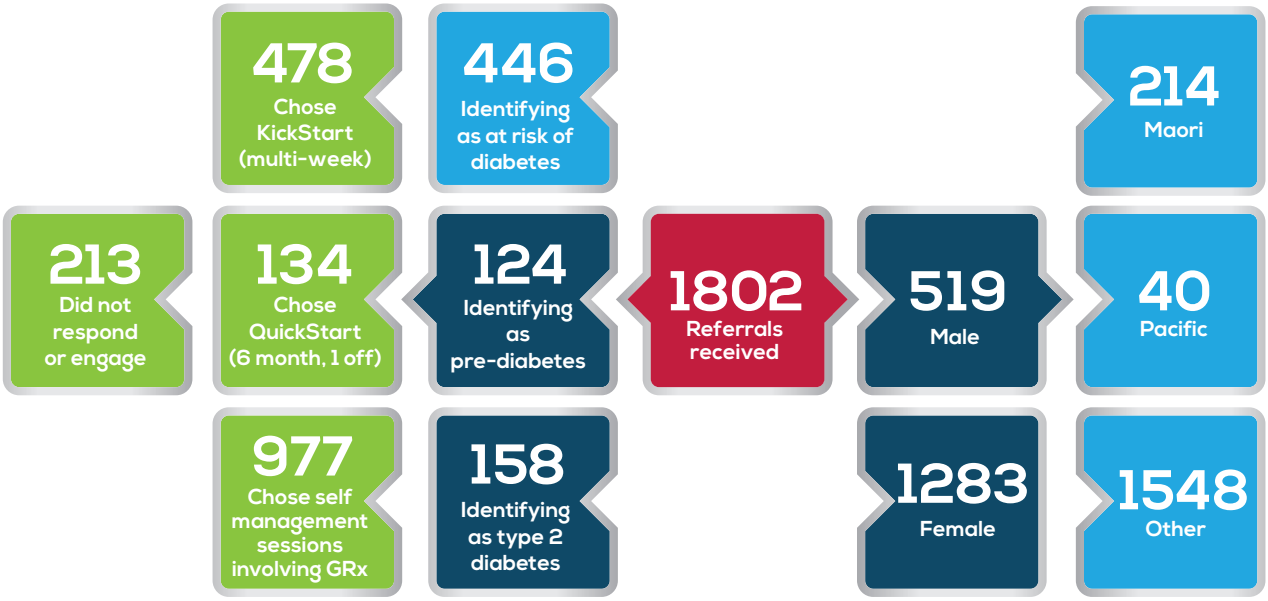
GRx is a referral option by which GPs, their practice staff, and other health care providers promote physical activity and healthy eating to their patients by referring to GRx for motivation and support. The expectation from Ministry is that GRx reaches people with, or at risk of, Pre-diabetes and Type 2 diabetes.

GRx staff offer choices for those referred which includes specific GRx programmes such as:

- **QuickStart** – a 2.5 hour session designed to explore personal beliefs, motivation, change and goals: aim being to get people in the right stage of change.
- **KickStart** – a multi-week programme, that builds confidence through a cohesive group, and habits by attending weekly. This programme involves education and a sample of various physical activities. Delivered in partnership with aquatic facilities around the region.
- **Condition specific self-management sessions** such as Living with Type 2 Diabetes; Reversing Pre-Diabetes; Upright & Able for falls prevention; The Joint Programme – osteoarthritis hip & knee or Healthy Hearts.

PERFORMANCE

The contractual obligations for GRx referrals during 2016/17 year is **1841**. This includes at least 200 people with or at risk of Pre-diabetes or Type 2 diabetes.



Green Prescription

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Evaluation feedback at the completion of Green Prescription intervention demonstrates an overwhelming appreciation of the impact Green Prescription has had on people's health and well-being.

The results from the most recent cycle of KickStart:

- **100% of attendees understand why they need to be active.**
- **81% of attendees have become more active since beginning GRx**
- **63% of attendees have made positive changes to food since beginning GRx**
- **82% of attendees have noticed positive changes to their health**
- **100% feel supported to initiate and sustain good lifestyle choices**

IS ANYONE BETTER OFF?

Traditionally the Ministry of Health has undertaken an annual patient satisfaction survey, however this has not been done this year so GRx has developed a follow up questionnaire to obtain self-reported outcomes at 3, 6 and 12 months post GRx intervention.

So far results reflect...

GRx has stepped outside the 'norm' and developed a completely different delivery model, in the hope of finding a more effective and efficient delivery model while retaining patient outcomes. The evidence so far is telling us this one-off session is working as effectively as a multi week programme.

PERSONAL SUCCESS STORY:

> ***Green Prescription has made me aware of other areas in my life that can be better, and I am working on that. I have very low self-esteem (not what I'm here for) and am realising that I alone can improve – and am, thank you! My pain (why I am here) in my knees is a lot better – thank you again***

MAORI HEALTH ACTIVITIES

- 11.8% of referrals received identified as Māori.
- Currently working in partnership with Te Piki Oranga Motueka (located at Te Āwhina Marae) to establish and support ongoing physical activity options for staff and whanau. So far we have delivered one training session (train the trainer) to staff around pedometers and got them started on a step challenge using pedometers on loan from GRx.

The Joint Programme

Osteoarthritis (Hip & Knee) self-management

PURPOSE Improve the quality of life for people with osteoarthritis

OBJECTIVE

Deliver a 'one-off' self-management session in partnership with Green Prescription, that builds knowledge and confidence of those attending to manage weight, manage pain and increase physical activity levels

PROGRAMME OVERVIEW

The Joint Programme is a 3 hour "one-off" session for people experiencing osteoarthritis pain, and is designed to empower and build confidence to live a healthy life.

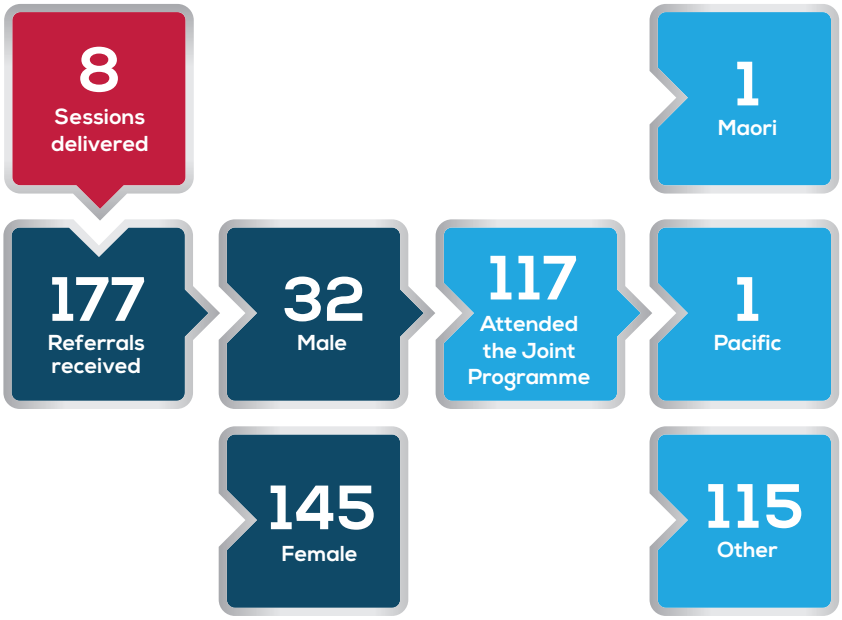
The session includes interactive discussions and information on:

- eating for healthy bones and weight loss
- keeping mobile/exercise regularly to support joints and manage pain
- taking pain medication as prescribed

The session was developed and clinically supervised by the Rheumatology Nurse Specialist and the Chronic Pain Specialist. The session has also been peer reviewed by Nelson Marlborough Health hip & knee replacement team, Orthopaedic specialists, general practice nurse and community physiotherapist.

PERFORMANCE

Funding was secured for this programme in December 2016, so delivery started January 2017.
In the 6-months since commencement we have achieved:



The Joint Programme

Osteoarthritis (Hip & Knee) self-management

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Reasons for attending the programme were:

- **18% wanted to learn more about hip or knee surgery**
- **68% wanted more information on how to manage their pain**
- **66% wanted to increase their knowledge of osteoarthritis**

Session evaluations shows:

- **99% of participants increased their knowledge of Osteoarthritis**
- **93% increased their confidence in managing their Osteoarthritis**

IS ANYONE BETTER OFF?

Participants followed up at 3 months showed...

PERSONAL SUCCESS FEEDBACK:

> ***"I now understand the value of taking paracetamol regularly to get my pain under control. It was interesting to learn how it works and that taking it as prescribed is how it works best"***

MAORI HEALTH ACTIVITIES

- Number of Māori referred: 6
- Number of Māori attended: 1
- Currently working with Te Piki Oranga staff in Motueka to plan culturally appropriate information on osteoarthritis for Māori.
- Also supporting Te Piki Oranga staff to develop *Te Oranga Pai* which will give Māori, and other high needs people within that community, a safe and suitable activity option in a supported environment.

Mental Health

Gateway Health

Assessment Service

...the welfare, interests and safety of children and young people are the first and paramount considerations

PURPOSE The Gateway Health Assessment Services aim is to ensure every child or young person who comes to the attention of Oranga Tamariki (formerly Child, Youth and Family) receives an assessment that helps build a complete picture of the child or young person's needs, and ensures that they get access to the right health and education services to address their needs.

OBJECTIVE

Nelson Bays Primary Health (NBPH), Nelson Marlborough Health, Oranga Tamariki and the Ministry of Education are working together to identify and respond to children and young people's health and education needs.

PERFORMANCE

NBPH employs a Health Information Technician to coordinate Gateway (0.5 FTE). NBPH has continued to build and refine the structure to ensure that there is a clear process of making and receiving referrals. Systems have been improved and information sharing between agencies continues. Oranga Tamariki social workers are familiar with the referral process and have seen the benefits of making such a referral. Follow up training for social workers has been provided.

PROGRAMME OVERVIEW

All referrals for the service originate with Oranga Tamariki when children/young people come into care or go through Family Group Conference proceedings. Professionals participating in Gateway from all three ministries recognise that these clients are the most vulnerable members of our community, and that the welfare, interests and safety of children and young people are the first and paramount considerations.

Health information for each client is collated into a file, along with a detailed education profile completed by the education provider. This file informs the physical exam, which is performed by a paediatrician. The paediatrician summarises the findings, key issues and recommendations into a health report, which forms the basis of an Interagency Service Agreement (ISA). The ISA is then reviewed at a monthly multidisciplinary panel meeting where local services are provisioned based on the needs identified at the assessment.

DESCRIPTOR	Q1	Q2	Q3	Q4	TOTAL
Health assessments	10	9	11	18	48
Referrals	16	8	12	22	58
Interagency Service Agreements (ISAs)	8	8	5	17	38

Top 5 Health Needs Identified

1. **Exposure to family violence**
2. **Parental support**
3. **Neglect**
4. **Poor engagement with health services**
5. **Housing problems**

Top 5 Education Needs Identified

1. **Small group**
2. **Coping, managing emotions, dealing with stress**
3. **Numeracy**
4. **Literacy**
5. **Paraprofessional support: teacher aide, mentor, tracker**

MAORI HEALTH ACTIVITIES

This service is expected to be culturally appropriate, to meet the needs of Māori service users/tangata whaiora, and to establish operational links with existing Māori health providers.

A Māori representative sits on the Gateway Panel and assists in the identification of and improvement in the cultural perspective and cultural practice for children/young people going through the Gateway programme.

PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC

ETHNICITY DESCRIPTOR	Q1	Q2	Q3	Q4	TOTAL
Māori participation	4	0	4	2	10
Pacific Island participation	0	0	0	0	0
Asian participation	0	0	1	3	4
Refugee participation	0	0	0	0	0
Gender: Male/Female	7/9	5/3	7/5	11/10	30/27

Mental Health Services

Children in Care

PURPOSE To facilitate and coordinate the delivery of appropriate mental health services to meet the primary mental health needs (behavioural and/or emotional) for children and young people in the care of Oranga Tamariki (previously Child Youth and Family -CYF) identified through a Gateway Assessment across Nelson and Marlborough.

OBJECTIVE

Facilitate and coordinate the delivery of mental health services which:

- Deliver according to a set of commonly agreed practice principles and values to guide the providers of services
- Outline details of the service delivery processes and expectations
- Assist providers to deliver the services consistently across Nelson and Marlborough

PROGRAMME OVERVIEW

Nelson Bays Primary Health (NBPH) is the contract holder for delivery of these services across Nelson and Marlborough. NBPH works alongside the Marlborough Primary Health, who holds the contract for the Gateway Assessment process for Marlborough, to ensure the seamless service delivery of the primary level mental health packages of care for children and young people in Marlborough.

The service provided by NBPH is made up of the following components:

- Participation at the Gateway Assessment panel meeting in Nelson and Marlborough
- Undertaking service planning across the district
- Coordinating the delivery of Oranga Tamariki endorsed interventions in Nelson and Marlborough
- Liaison with other relevant services and practitioners

PERFORMANCE

For the 2016/17 year, NBPH has processed 10 referrals for this service. These are usually generated by the Gateway Assessment process, in Nelson and Marlborough, where children/youth have been identified as being appropriate for packages of care via the primary level mental health services. One of these were referred from Marlborough.

The Gateway Assessment Coordinator and team continues to work alongside Oranga Tamariki staff to complete the integrated service agreement plans (ISAs). This relationship and its progress will continue to generate new referrals for primary mental health packages of care.

ORANGA TAMARIKI
Ministry for Vulnerable Children

NBPH continues to review the overall Gateway referral and assessment process to ensure this best meets the needs of this population group and provides appropriate mental health and well-being support to improved outcomes. The Gateway Coordinator takes a proactive role, ensuring that children and young people move through the process more quickly. The completion of assessments does lead to an overall increase of referrals for mental health packages of care. The difficulty in utilising this service arises when there is any reduction in Gateway referrals coming from Oranga Tamariki - despite significant prompting and encouragement to their staff. Without these new referrals and subsequent health assessments, we are unable to prompt for the available packages of care.

NBPH have also met with management at Oranga Tamariki to help identify and address the blocks that have arisen in terms of gaining parental consent for referrals to proceed as well as how best to promote this resource for their vulnerable children & youth.

REFERRAL TARGETS (YEAR):

The annual target for referrals is for 30 children but this service has only processed a total of 10 referrals, mainly due to low numbers of Gateway referrals via Oranga Tamariki. This is an issue that has been highlighted at the Gateway Governance and Management meetings but is a common finding on a national basis.

MAORI HEALTH ACTIVITIES

Package of care referrals in Nelson Tasman by ethnicity for 2016-17

ETHNICITY	NUMBER	PERCENTAGE
NZ European	6	60%
Māori	4	40%
Total	10	100%

...it is estimated that approximately half of the children and young people known to Oranga Tamariki identify as Maori

PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC

It is estimated that approximately half of the children and young people known to Oranga Tamariki identify as Māori. In the last year, 40% of the referrals for packages of care referrals were for people who identified as Māori.

An overarching aim of the health sector is the improvement of health outcomes and reduction in health inequalities for Māori. Health providers involved in providing services are expected to provide health services to contribute to realise this aim. NBPH continues work to ensure that there is Māori participation in the decision making around, and delivery of, the services as outlined in this contract. A Māori representative sits on the multidisciplinary clinical panel to ensure that the needs of Māori are well represented.

Persistent Non-Malignant
Pain Programme

PURPOSE This Service aims to assist clients with gaining a greater understanding of their on-going pain, combined with strategies and coping skills to enable them to self-manage their pain more effectively. Referrals are accepted from General Practitioners and Specialists.

OBJECTIVE

The objective of the service is to provide sustainable, evidenced based Persistent Non-Malignant Pain assessment and management in a community setting, which will have a positive effect for the client, on whole families and reduce prevalence and effects of persistent pain in the Nelson Tasman region.

The service will work towards being an accredited service with the aim of obtaining ACC funding for a permanent Persistent Non-Malignant Pain Service in the district.

PROGRAMME OVERVIEW

The service is delivered by a multi-disciplinary specialist team, providing individual and group pain management interventions. The service delivers a biopsychosocial model of intervention to assist clients with:

- Increasing their overall activity participation
- Minimising any emotional distress experienced as a result of living with persistent pain
- Reducing reliance on medications and Emergency Department presentations

PERFORMANCE

Data collected from client pre and post intervention psychometric tests, indicates that clients have experienced improvement in their capacity to manage their symptoms, through participation in biopsychosocial pain management interventions.

CLINICAL IMPROVEMENTS FROM PSYCHOMETRIC TESTS

	YTD OVERALL % IMPROVEMENT
Visual Analogue Scale (VAS)	9%
Pain Disability Index	13%
Self Confidence Scale	22%
DASS Depression	15%
DASS Anxiety	7%
DASS Stress	11%
Tampa Scale Kinesiophobia (TSK)	14%
Pain Catastrophising Scale (PCS)	27%
MSPQ	8%
Functional Abilities Confidence Scale (FSA)	14%

Feedback obtained from client satisfaction surveys, indicates participants of the Persistent Non-Malignant Pain programme have experienced ***high*** satisfaction from intervention: 90% for the 2016/17 year.

Subjective feedback from GP's suggests good satisfaction with support provided by the Persistent Non-Malignant Pain team.

- **The Persistent Non-Malignant Pain team exceeded "consultation" targets by 59 clients**
- **The General Practitioner Special Interest (GPSI) has continued to provide best practice, evidenced based Pain management advise to GPs. This has included written updates sent to General Practice on best practice pharmacological management, one on one client assessments and virtual advice provided to GPs. On average, the GPSI attends to 2 telephone calls from GPs per week, requesting expert advice on Pain management for their patient(s).**
- **The Persistent Non-Malignant Pain team played a key role in the development of programme content and facilitation of the NZ Pain Society Conference, held in Nelson, March 2017.**
- **The Persistent Non-Malignant Pain has provided one on one and group based interventions to clients referred to the service.**
- **The Persistent Non-Malignant Pain team has continued to work closely with Services such as Alcohol and other Drug, Mental Health Secondary Care, Rheumatology, Medical/Allied health teams at Nelson Marlborough Health and Burwood Pain management teams.**
- **The NBPH team has continued to meet face to face with the led clinician at Marlborough Primary Health on a 3-6 monthly bases with regards aligning service delivery.**
- **NBPH team is fostering stronger relationships with ACC and Work and Income, with a view to expand services to meet population needs across sectors.**

The Persistant Non-Malignant Pain Programme team exceeded "consultation" targets by 59 clients

REFERRAL TARGETS FOR 2016/17

DESCRIPTOR	TARGET	Q1	Q2	Q3	Q4	YTD
Number of patients who have completed intervention and/or received specialist advise by the service (data includes GPSI virtual advice to GP's)	100	36	31	44	48	159

MAORI AND PACIFIC HEALTH ACTIVITIES

ETHNICITY DESCRIPTOR	TARGET	Q1	Q2	Q3	Q4	YTD
Māori referrals	NA	2	3	5	3	13
Pacific Island referrals	NA	1	0	0	0	1

Of the 13 Māori clients referred (5% of YTD referrals) seven clients chose to engage with the service (3%). One client identifying as Pacifica was referred to the programme, however chose not to engage in intervention.

Primary Mental Health Initiative

and Brief Intervention Service

PURPOSE To ensure that people with mild to moderate mental health problems have access to appropriate services as soon as possible, within available resources. The role of primary care practitioners is to ensure that individuals return to their full level of functioning by identifying and subsequently managing a mental health problem.

OBJECTIVE

These services will have an immediate and significant impact on health outcomes for consumers by empowering primary care providers to use more flexible and responsive alternatives for people with mild to moderate mental health problems.

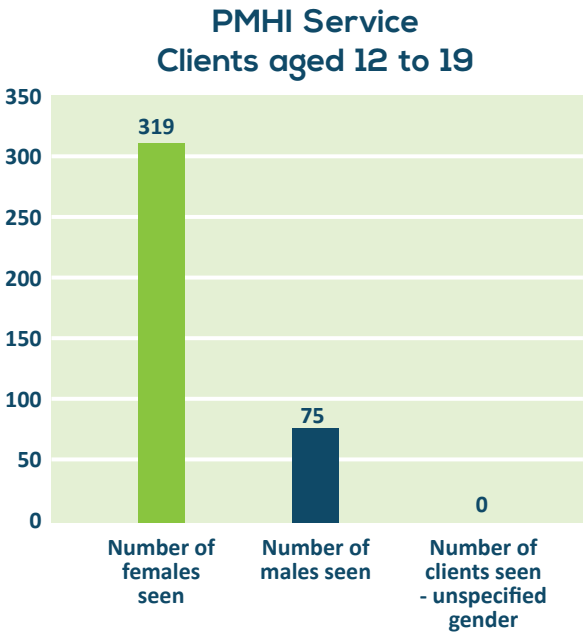
PROGRAMME OVERVIEW

Primary Mental Health Initiative service (PMHI) is provided by subcontracted providers located across the geographical area. Providers made up of Psychologists, Counsellors and Psychotherapists who provide between 3- 6 sessions (depending on clinician). Referrals available via GP or Māori Health Providers. This service is available to all age groups.

Brief Intervention Service (BIS) accepts referrals from GPs or Māori Health providers for clients aged 16 years old and over. This service is staffed by three clinicians who work from the Richmond site, with one of these based for two days per week in Motueka. Staff are trained in counselling and two are also registered nurses.

PERFORMANCE

GP practices are the main referrers to these services and usually provide an extended consultation for clients who present with mental health issues.



REFERRAL TARGETS (YEAR):

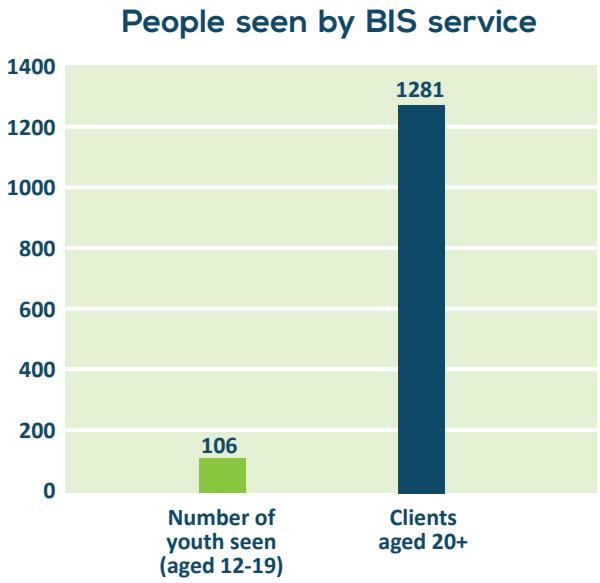
Targets for the year are 701 for both the PMHI service and BIS and referrals received are well over the target. The numbers shown above indicate the high demand for these services within the region.

MAORI HEALTH ACTIVITIES

Māori Health providers can refer directly to the Primary Mental Health Initiative or Brief Intervention Service.

Where ethnicity is stated 9.5% of the PMHI referrals and 9.1% of the BIS referrals for the year were for Māori tangata whaiora.

Not all referrals from Māori organisations are for Māori and not all consumers who are Māori have been referred by Māori organisations.



The table below shows the combined percentage of Māori clients over the last four quarters:

QUARTER	PERCENTAGE
July - Sept 2016	10.3%
Oct - Dec 2016	11.5%
Jan - March 2017	7.5%
April - June 2017	8.6%

The outcome measurement tool used by this service is the PHQ9. Clients complete the outcome measure at the beginning and it is repeated at the end of service provision with the goal being a reduced score. There was an average result of a 4.5 drop in PHQ9 scores for Māori clients who accessed PMHI & BIS for the past year.

Strengthening Families

PURPOSE Strengthening Families is an independent facilitated process that enables family/whanau to meet with the support services they need or want when trying to overcome any challenges that are stopping them from moving forward and becoming a strong effective family/whanau unit.

OBJECTIVE

To ensure that the family/whanau have the most effective support available to enable them to reach their potential as a family/whanau.
The process is family centred and family driven and can be used as a referral pathway or a way of making sure all agencies/organisations are on the same page and co-ordinated.

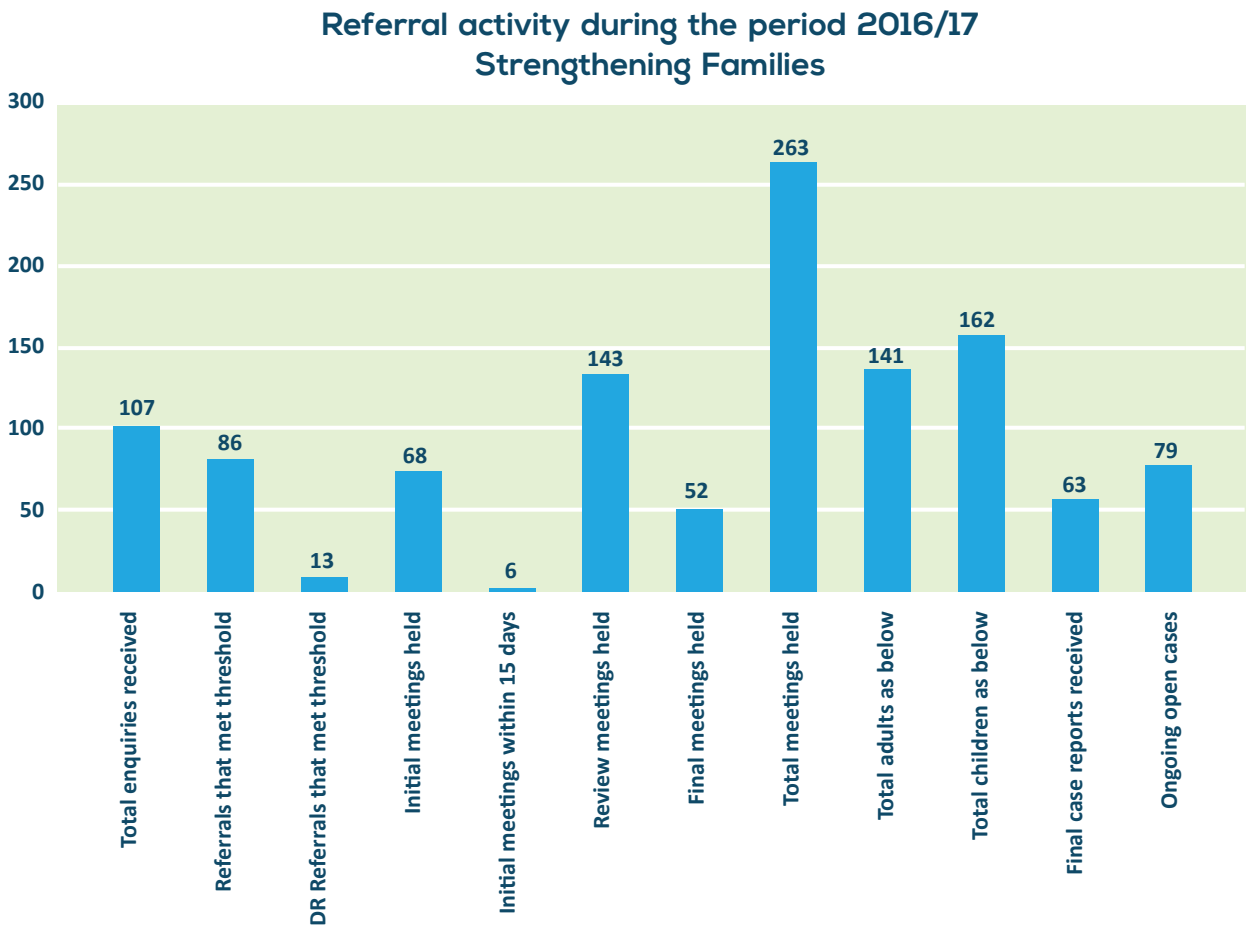
PROGRAMME OVERVIEW

The programme is a perfect example of quality collaboration between government sector and NGO's to make sure families/whanau are supported by all the agencies that are appropriate for them to reach their full potential.

Strengthening Families continues to receive positive feedback from participants and their family/whanau...

PERFORMANCE

For Ministry of Social Development, the contractual obligation was 100 families/whanau for the year 2016/17. For the 2016/17 financial year Strengthening Families received 107 enquires and referrals. 98% of enquiries eventually become referrals.



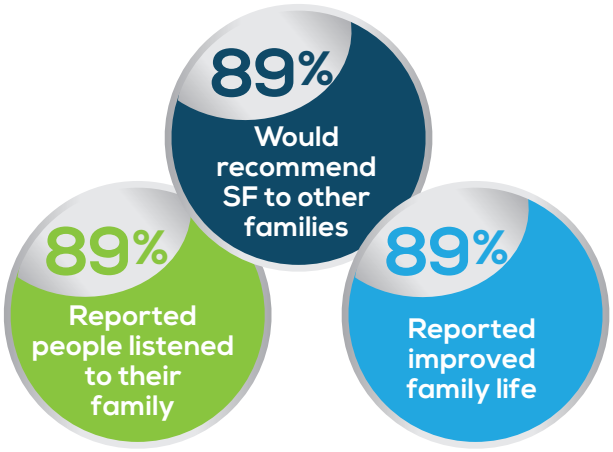
OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

- **Strengthening Families continues to receive positive feedback from participants and their family/whanau from this process.**
- **Evaluations Received from 34 participants included:**
- **People listened to my family/whanau – 89%**
- **Strengthening Families has improved our family/whanau life – 89.7%**
- **Strengthening Families helped our family/ whanau – 87.5%**
- **My family/whanau got access to the services we needed- 92.9%**
- **The lead agency kept us informed on our action plan – 90.4%**
- **We would recommend Strengthening Families to other families/whanau – 89.7%**
- **My culture/ethnicity was respected at Strengthening Families meetings – 89%**

Strengthening Families

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

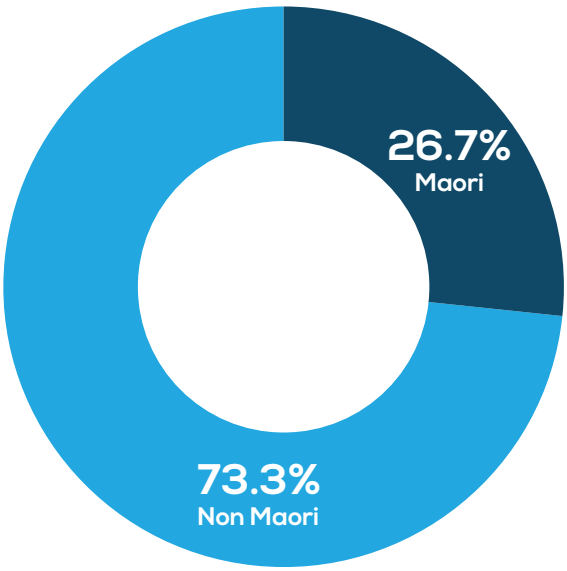
Evaluations from Strengthening Families participants showed...



MAORI HEALTH ACTIVITIES

During 2016/17 Strengthening Families has begun to work closely with Te Piki Oranga and Whakatu Marae. There are now 3 Facilitators from Whakatu Marae who are training as facilitators. Strengthening Families has strong support from Te Piki Oranga with most navigators becoming Lead Agents when a Whanau involved in Strengthening Families also has Te Piki Oranga involved. Te Piki Oranga are now a member of the Strengthening Families Strategic Management Group as well as a signatory for Discretionary Fund applications. Te Korowai Trust have 2 facilitators and are very involved in the Strengthening Families process.

PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC



ETHNICITY	NUMBER	PERCENTAGE
Māori	23	26.74%
Non Māori	63	73.26%
Total	**86**	**100.00%**

23 families out of 86. 67 children.

Targeted Youth Health Service

PURPOSE To improve outcomes for students in Alternative Education (AE) and in Teen Parent Unit (TPU) by providing health assessments, improving access to primary health care and improving interagency partnerships.

OBJECTIVE

To develop a service which is responsive to young people – particularly rangatahi (Young Māori), who suffer poorer health than their peers. On the basis that healthy young people become healthy adults, it is in the community's best interest to focus on keeping young people well and to find more effective ways of doing this.

The service objectives are to:

- Improve the access to primary health care of young people with high needs, specifically students in Alternative Education (AE) and in Teen Parent Unit (TPU)
- Ensure that appropriate and timely referrals are made in order to improve youth health and reduce inequalities
- Promote overall improvement in the provision of services to young people in this district, through developing workforce and best practice approaches

PROGRAMME OVERVIEW

The service is provided by Nelson Bays Primary Health (NBPH) and provides nursing services delivered in Nelson. This service is primarily a mobile nursing service provided by a registered nurse who is skilled in youth health and youth development. The clients of the service are students enrolled in Alternative Education (AE) and Teen Parent Unit (TPU). The focus of the service is on improving outcomes for individuals and reducing inequalities.

Weekly youth health clinics are held on site during term time at:

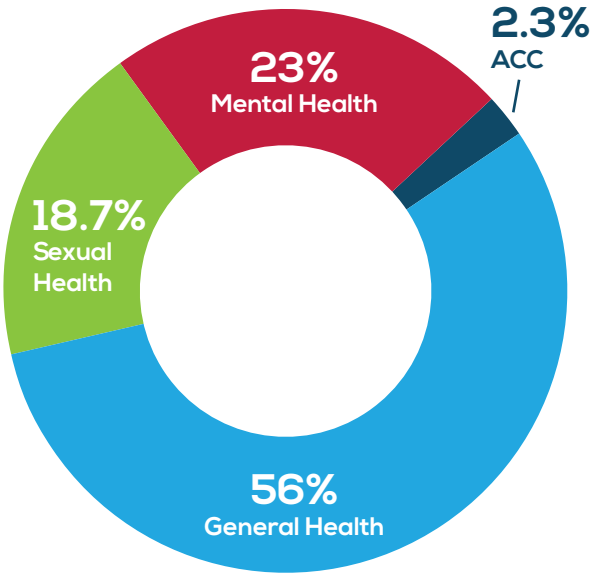
- Abel Tasman Education Trust (AE/YTS)
- @ Your Potential (AE)
- Youth Nelson (AE)
- Nelson Young Parents school (Nelson)

And fortnightly at YMCA Pathways program

PERFORMANCE

INTERVENTION	1 JULY 2016 TO 30 JUNE 2017
Initial youth health check (total)	63
Student visits - for advice, treatment & referrals	193
Routine Assessments including Heeadsss	16
Annual Health Checks	16

HEALTH NEEDS



Targeted Youth Health Service

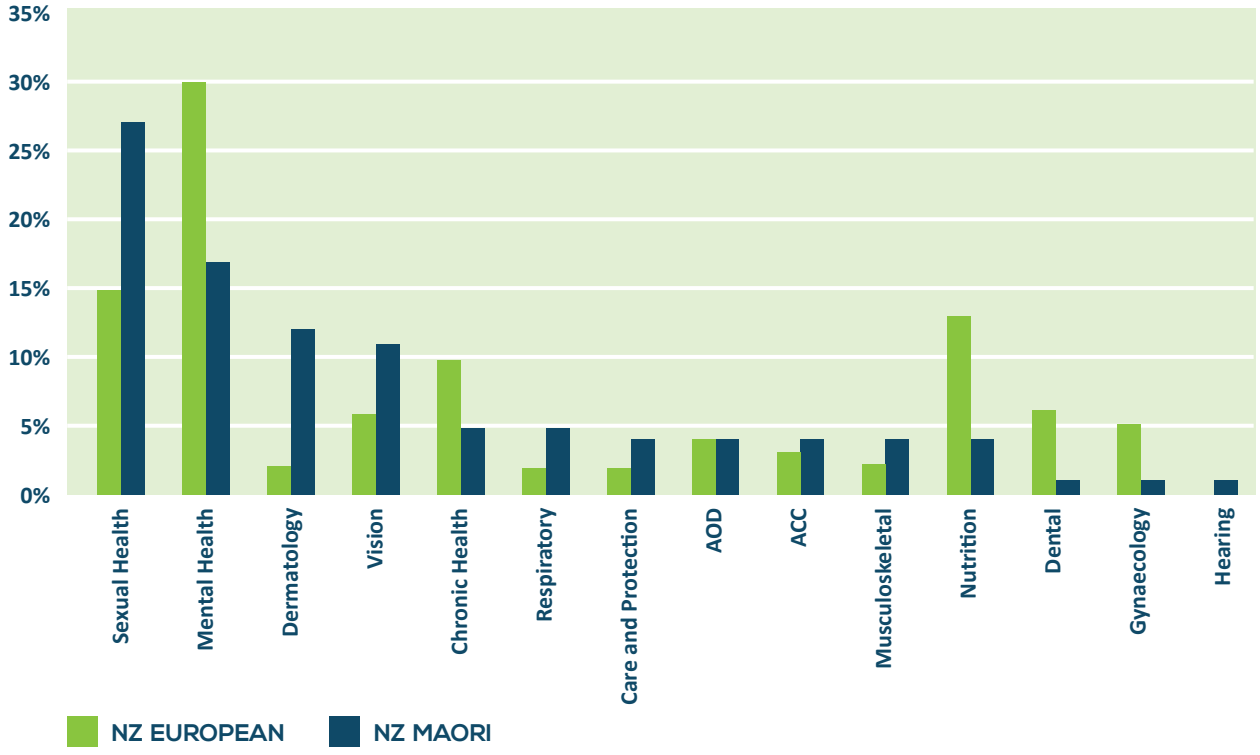
PERFORMANCE *continued*

REFERRAL TARGETS (YEAR):

The Targeted Youth Health Service continues to deliver 100% on its contractual obligations to see all the new students at alternative education for provisions of a health assessment. The service ensures that all young people/rangatahi who receive a youth health check are enrolled with a primary health provider. The Targeted Youth Health Service identifies health needs via an initial assessment, an annual youth health check, referral and follow-up process. The highest percentage of assessments are in the 15-17 year age range. Through the initial assessments and follow-up consults, 776 health needs were identified during the full year.

MAORI HEALTH ACTIVITIES

Figure 1. Comparison of issues identified between New Zealand European and Māori young people enrolled in the TYHS.



PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC

This service has typically seen a considerably high percentage of Māori. For the last year, of the health assessments completed 39% of the clients identified as Māori. Māori young people had significantly higher health concerns compared with non-Māori of; sexual health, dermatological and visual.

Te Piki Oranga has been working with ATET and Nelson Young Parent School on their wellbeing program which has been well received.

Youth Alcohol and Other Drug (AOD) Service

PURPOSE To provide Alcohol and Other Drug (AOD) and potentially co-existing Mental Health Brief Intervention treatment, therapy, support and care coordination service for young people in Nelson Tasman. This is a mobile, community-based service aligned to primary mental health, and accepts referrals from the Targeted Youth Health Service and via Community Care Coordination Service from primary health care providers, schools and other agencies who work with young people.

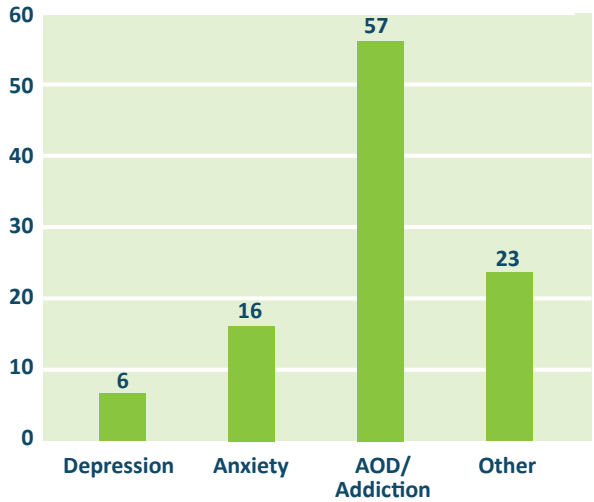
OBJECTIVE

To deliver a Youth AOD Brief Intervention service which:

- Is mobile, community-based and culturally appropriate
- Improves the access to AOD and Mental Health services for young people who demonstrate mild - moderate alcohol or drug behaviours/ disorders with/without underlying mental health issues
- Provides a brief intervention focused service to youth across the Nelson Tasman region for ages 12-20 years.

PERFORMANCE

Youth Seen July 2016 to June 2017



PROGRAMME OVERVIEW

The service uses a youth participation model.

The service is flexible and meet the needs of young people and be aligned to the Nelson Bays Primary Mental Health Brief Intervention and Targeted Youth Health Services in Nelson Tasman, and the Nelson Marlborough Health Addictions services and Child and Adolescent Mental Health services.

The service can accept referrals for children and young people with alcohol and other drug disorders with co-existing anxiety, depression, phobias and behavioural disorders if it is clinically appropriate.

The service includes screening and the use of brief assessment tools such as the Strengths and Difficulties questionnaire (SDQ) or the Substance Use and Choices Scale (SACS).

Expected maximum intervention of up to 4 sessions- brief intervention model. These interventions are mainly in the form of one-on-one counselling sessions.

Liaison and consultation to other providers of health services and linkages with school guidance counsellors for referrals both ways are maintained.

Youth Alcohol and Other Drug (AOD) Service

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

For the full year, the Youth AOD clinician received a total of 102 referrals from across the district. These included approximately 54 % of the total referrals coming via the Emergency Department for follow up for youth who presented due to either alcohol or substance use issues.

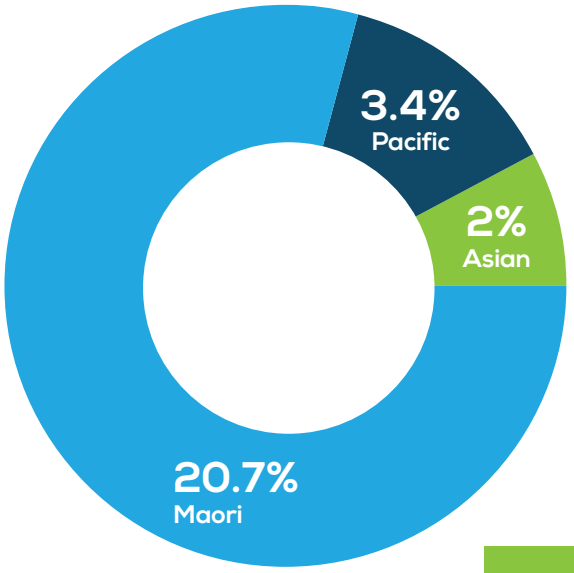
Clinics are held weekly across the major secondary schools and close liaison is maintained with other community youth agencies. NBPH Youth AOD clinician meets weekly with the Nelson Marlborough Health Youth AOD team, which supports this service across the continuum of primary to secondary care needs.

Youth are referred onward to services such as Brief Intervention Service (BIS) or Primary Mental Health Initiative (PMHI) if mild to moderate mental health needs are identified. Youth within the alternative education places often have more moderate to severe mental health needs. This is a gap as often they do not wish to engage with secondary services.

REFERRAL TARGETS (YEAR):

Previous contracts there has been a target of a minimum number of 30 Youth to be seen. There is no target set within the new contract and more focus is on provision across the community to reach youth, particularly within settings where they attend for their education needs.

PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC



MAORI HEALTH ACTIVITIES

Māori youth/rangatahi have predominantly been engaged via the Alternative education places and are connected with appropriate support services such as Te Piki Oranga- who are also engaged within these settings. These rangatahi are extremely vulnerable, with frequently complex health and social needs and therefore require more wrap around services to achieve positive outcomes.

Working in conjunction with Te Piki Oranga staff as well as the Education providers themselves, helps to support and encourage healthier choices and provides for ongoing educational opportunities.

ETHNICITY	PERCENTAGE
Māori	20.7%
Pacific	3.4%
Asian	2%

Kaiatawhai Service

Kaiatawhai Service Overview

PURPOSE The purpose of the Nelson Bays Primary Health (NBPH) Kaiatawhai Liaison service is to work with general practices and primary health care providers to support the health and well-being of their patients/clients in the Nelson Tasman region. This service focuses on supporting Māori, Pacific, High Needs patients and their whānau enrolled with a General Practice, to access health screenings and services that are available to them, such as: cardiovascular disease risk assessments (CVDRA), cervical smears, mammograms, vaccinations and diabetes annual reviews.

OBJECTIVE

To support Māori, Pacific, Migrant and high needs patients and whānau to:

- Access general practice health care and assessments for which they are eligible
- Provide extra focus on hard-to-reach enrolled patients and whānau/family
- Support patient referrals to other health providers and community services
- Work with general practice in the development and the facilitation of patient wellness plans
- Where possible include whānau in all of the decision making
- Support whānau/family members not enrolled with a General Practice to enrol

PROGRAMME OVERVIEW

The Kaiatawhai Liaison service is a care coordination, navigation and case management service. The Kaiatawhai Liaison staff work with the General Practice, other primary health care providers and community-based providers to improve the health and wellbeing of patients and whānau in the Nelson Tasman region. The service has a number of referrers such as Nelson hospital services, government agencies, community providers and self-referrals.

PERFORMANCE

The following shows the number of referrals to the service over the last four quarters and their ethnicity. The service was low in the second quarter due to a staff member leaving and time taken to recruit to the position.

DESCRIPTOR	TARGET	Q1	Q2	Q3	Q4	YTD
Kaiatawhai Service	n/a	110	64	140	146	460
Previous quarter	n/a	95	85	42	25	247

ETHNICITY DESCRIPTOR	TARGET	Q1	Q2	Q3	Q4	YTD
Māori participation	n/a	31	29	29	28	117
Pacific Island	n/a	4	3	4	2	13
New referrals	n/a	15	64	98	146	323

Note: Previous quarter referrals are patients who have been referred to the service and the reason for the referral has not been achieved or achieved completely. This is predominantly due to complex issues.

Approximately 95% of referrals come from General Practice. Patients referred from General Practice usually come because the patient has not replied to an invitation letter or phone calls inviting the patient in for a health assessment that is due.

When contact is made the patient may need other support such as:

- Supporting whānau to access general practices with phone calls, arranging appointments, transport, accessing other services to gain support to access general practice e.g. Māori health providers and whānau support
- Attending the assessments with whānau to help them understand the health terminology
- Follow up appointments after assessments
- Developing care plans in conjunction with practice nurse or doctor
- Supporting whānau to meet their goals and objectives identified in the care plan
- Physical health checks including monitoring and taking bloods
- Health Education e.g. diabetes, nutrition, oral health
- Making referrals to other services and sometimes attending the initial appointment with the whānau
- Completing patient and whānau needs assessments, whānau cultural assessments
- Developing resources

Kaiatawhai Service Overview

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The main referrer to the service is general practice who provide approximately 95% of the referrals. The main reason for referrals this year are cervical smears, followed by smoking, mammograms, immunisation, diabetes annual review and cardiovascular risk assessments. All of these contribute to achieving national targets.

Other services provided to clients include support to attend general practice appointments and other health appointments, referral on to other providers for support and assistance to develop patient plans to meet their current needs. This service also provides health information and resources to patients and whānau to help them make more informed choices.

NARRATIVE EXAMPLE:

Grandmother referred 4yr old grandson to the Kaiatawhai service after she gained consent from her daughter-in-law. 4yr old grandson was suffering from a severe eczema breakout. A meeting was organised with the mother to discuss treatment regime and any issue that needed to be addressed. Mother stopped using the creams on her child, saying he cries as it hurts. The mother required understanding about the creams, how to apply the cream and a bit of encouragement. A plan was developed with the whānau, Kaiatawhai service and general practice to support the mother. Improvement was monitored and a follow up with General Practice was made.

The eczema is now clear and the 4yr old is now able to tell mum before the skin starts to break down so as to start the regime again. He is now able to apply the cream himself under supervision.

During this time another referral regarding the same patient came from the Audiology department Nelson Marlborough Health. The 4yr old had hearing aids and was overdue for a check-up. Because of the relationship with the whānau an appointment was made and support provided for the whānau to attend the Audiology appointment. The 4yr old was not using his hearing aid because they were not working due to flat batteries. After some education and encouragement the 4yr old is now wearing his hearing aids with encouragement from the whānau.

Community Liaison and Feedback

Victory Community Centre Health Service

SUBCONTRACTOR PROVIDERS

Nelson Bays Primary Health funds a number of sub-contractor providers to deliver services on our behalf across the community.

These include:

- The Nelson Asthma Society
- Golden Bay Community Workers
- Motueka Community House
- Motueka Family Service Centre
- Red Cross Nelson
- Mapua Podiatry

Victory Community Centre Health Service is also one of the subcontractor providers. Below is a summary of their work:

PURPOSE The purpose is to provide a health and social service coordination role to facilitate patient pathways, identify needs, gaps and any barriers to accessing services. To provide direct access support for those facing barriers to accessing primary health and social services, particularly to support enrolling patients with general practice.

OBJECTIVE

The objective of the service is to provide a navigation and case management service for any individuals and groups seeking primary health care support. The service:

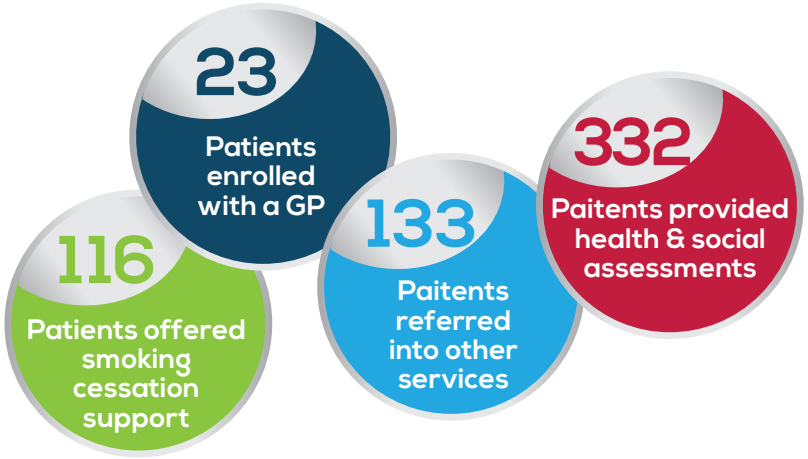
- Supports individuals and groups to better understand how and where to access primary health care, and wellness support services they require.
- Provides initial assessments where appropriate and develop a plan for the client and provide suitable support where required.
- Identifies barriers and work with individuals and whānau to reduce or eliminate barriers.
- Facilitates unenrolled people to become enrolled with a general practice
- Supports individuals to access health screenings i.e. cardiovascular risk assessments

PROGRAMME OVERVIEW

The service may be the first point of call for client(s) and whānau when accessing primary health care and as such, forms an important link with health professionals. The main objective is to improve health outcomes for their clients by working in the following manner:

- Advocating for whānau when the need arises in the area of health and social services
- Educating and informing whānau about health services, health issues and general health matters concerning whānau
- Providing links and consultations between whānau, community and service agencies
- Developing demographic profiles of whānau and the community they live in
- Maintain a list of key health services, community groups and organisations in the area
- Strategically plan and implement programmes for target groups in the area which assess disease prevention, health education, independence and healthy lifestyles
- Provide client and whānau assessments to determine the need of the client and whānau where appropriate
- Develop a client and/or whānau plan to address client need where appropriate

Over the past year, the Victory Community Centre service provided...



Community Liaison and Feedback

Victory Community Centre Health Service

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

DESCRIPTOR	TARGET	Q1	Q2	Q3	Q4	TOTAL
Number clients accessing service	N/A		120	107	114	341
Māori participation	N/A		34	39	35	108
Pacific Island	N/A		8	3	1	12
Health & social assessments	360	89	81	73	89	332*
Enrolling clients with a general practice	N/A	6	1	5	11	23
Asked smoking status	240	64	56	64	89	273
Offered brief advice	N/A	64	16	17	19	116
Number of clients supported to access other services	N/A	55	34	30	14	133

*Total below target by 28 assessments. This was due to health nurse retiring and the time required to recruit a new nurse.

Victory Community Centre provides services to vulnerable and at risk whānau with high needs. The provision of health and social service assessments identify emerging health issues, prevention and maintenance of health conditions. The service provides navigation support to access many other services. Much of the work undertaken by Victory Community Centre is the back end support the enable patients to attend health clinics, appointments and completing health plans successfully.

Over the past year the service has offered 116 patient smoking cessation support, referred 133 patients onto other services, enrolled 23 patients with a general practice and provided 332 health and social assessments. This is in addition to other support provided to the patients to achieve their health plans and access to other services.

Future planning - Victory Community Centre have secured funding to get MedTech, allowing them to access referral pathways. The service is working closely with Harrison and Moore Medical to develop robust health services including standing orders, family planning, contraception, sexual health and cervical screening. This will enable opportunistic services to be provided as relevant.

MAORI HEALTH ACTIVITIES

Victory Community Centre have a high number of Māori residing in the Victory area. Over 30% of the clients accessing Victory Community Centre health service have identified as Māori. The service has developed a close relationship with the Kohanga Reo based at the School to provide support as required.

Community Podiatry Service

PURPOSE The contract requires the delivery of podiatry services to individuals with at-risk and high-risk foot complications related to diabetes. There are other conditions that require podiatric input to maintain mobility and help prevent ulceration and possible amputation. Specialist podiatry services may also be provided for others with diabetic at-risk and high-risk feet, including, but not limited to, those with rheumatologic disorders, or severe peripheral arterial disease. Allocation for provision of these services is based on the level of disability and the capacity to benefit.

OBJECTIVE

NBPH has a contract with Mapua Podiatry to deliver a community-based podiatry service which entails interdisciplinary, cross-sectoral care teams providing comprehensive, holistic and continuous health services to enrolled populations of people.

- To improve the quality of podiatry care for individuals with diabetes and individuals with at-risk and high-risk feet;
- To develop and provide a patient-centred, integrated model of care for the prevention and treatment of at-risk and high-risk feet problems in community and hospital settings;
- To support the diabetes treatment plan agreed by the individual and their primary/secondary provider;
- To ensure that health practitioners including general practitioners (GPs), practice nurses and diabetes clinical nurse specialists, and nurse practitioners have the knowledge and skills to identify foot problems early and understand the pathway for their management.

PROGRAMME OVERVIEW

The podiatry service is a mobile service which works with primary care, secondary care specialist services, providers of diabetes education and management, and Māori health providers that provide facilitation services or support for people with diabetes and their whānau.

PERFORMANCE

DESCRIPTOR	TARGET	Q1	Q2	Q3	Q4	TOTAL
Podiatry Service	2540	682	656	580	566	2484

ETHNICITY DESCRIPTOR	TARGET	Q1	Q2	Q3	Q4	TOTAL
Māori	N/A	86	77	74	75	312
Pacific Island	N/A	8	12	9	11	40

Community Podiatry Service

The podiatry service is a mobile service which ... provides facilitation services or support for people with diabetes and their whanau.

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The Podiatry Service objective is to improve the quality of podiatry care for individuals with diabetes and individuals with at-risk and high-risk feet. The activities of this service support the provision of podiatry care to patients with diabetes, this includes foot care plans, education and good foot care promotion.

This includes preventative and maintenance measures to patients with diabetes and individuals with at-risk and high-risk feet that support them to manage their condition and remain in the community. This reduces the demand on secondary health care and gives greater independence to patients and whānau.

GENERAL COMMENT:

Demand for the service is very high and the waiting list can dramatically fluctuate. Overall the year has been very busy with patients booking appointment times and are often required to rebook when their appointments are missed, due to a variety of reasons. Clinics are working well in Nelson, Motueka and Golden Bay and a number of afternoons are provided to complete house calls in Motueka for patients who are unable to attend clinics in town.

MAORI HEALTH ACTIVITIES

The Podiatrist has developed a model of collaboration with two of the local marae, Whakatū and Te Āwhina marae and with Te Piki Oranga the Māori Health Provider. The Podiatrist and Te Piki Oranga provide clinics on the marae. While patients are waiting to see the Podiatrist, Te Piki Oranga health staff offer free health checks. Māori participation in these clinics are very high and feedback from patients is very complementary to all services provided, especially the Podiatry service.

Specialist Services

Infectious Diseases Service

PURPOSE To reduce the incidence and optimize the treatment of infectious diseases and antibiotic-resistant organisms in Nelson and Marlborough.

OBJECTIVE

1. Individual patient care – to support primary and secondary care colleagues to diagnose and treat individual patients with infections
2. System improvement
   a. Antibiotic stewardship – to monitor the local infectious disease epidemiology and guide colleagues to prescribe rational and cost-effective antimicrobial for primary and secondary-care patients

b. Infection prevention and control – to guide primary and secondary care services and colleagues to prevent acquisition and spread of infectious organisms

c. Microbiology laboratory – to optimize requesting of laboratory tests and guide the laboratory staff to provide up-to-date, accurate and cost-effective testing of samples and effective reporting of results

3. Advance knowledge
   a. Education and collegial linkages – to be well educated and be connected with national and international colleagues and activities

Research – to undertake selected, high-quality, high-impact studies of important local problems then publish and present the results nationally and internationally for the benefit of other health-care services and patients.

Waiting times are no longer than a week, often within 24-48 hours with the use of direct phone consultation

PROGRAMME OVERVIEW

1. Individual patient care: outpatient clinics (face-to-face, virtual; Nelson and Wairau), consultations (phone, inpatient visits)
2. Antibiotic stewardship: run outpatient intravenous service, develop antibiogram, write antibiotic guidelines for inpatients and primary care, audit prescribing, education, moderate New Zealand Infectious Diseases/ Microbiology email network and website
3. Infection prevention and control: chair IPC committee, liaise with Nelson Marlborough Health IPC nurses, support Public Health service, member of New Zealand IPC advisory group, maintain Nelson Marlborough Health IPC guidelines and documents, promote staff vaccination, manage staff infective exposures, support outbreak control, education
4. Clinical microbiology laboratory advice: advise on development of protocols and clinical laboratory issues
5. Education and collegial linkages: attend national and international conferences, attend local peer review and journal club meetings, self-education
6. Research: five-year probenecid pharmacokinetic and clinical trial project; duration of antibiotic project; pre-op topical prophylaxis for SSI prevention

PERFORMANCE

DESCRIPTOR	TARGET	ACTUAL	COMMENT
Telephone consults (est. work calls/Q)	–	1083	
Outpatient assessments (N+W)			
– New face-to-face	–	40	77% of all outpatient assessments were virtual
– Follow-up face-to-face	–	64	
– New virtual	–	86	
– Follow-up virtual	–	269	
– New patient wait (mean, days)	< 120	100%	
– Face-to-face DNAs (new or follow up)	< 5%	5/104	
Inpatient assessments	–	31	
Teaching presentations in New Zealand	>10/yr	32	3 national conferences
Audits in Nelson/Marlborough	>5/yr	10	
Inpatient AB guidelines up-to-date	95%	64%	
Antibiogram up-to-date	Yes	Y	
myCPD maintained (RACP CME)	Yes	Y	
Peer supervision and review of me (hr)	10 hr/yr	29	

NBPH's Specialist has started a South Island guideline writing group to share the workload to catch up on the antibiotic guidelines.

REFERRAL TARGETS (YEAR):

No targets for referral numbers. Targets for waiting time and DNAs met.

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Responsive service provision across primary and secondary care environments. Waiting times are no longer than a week, often within 24-48 hours with the use of direct phone consultation with the referred clients. This is received positively by the clients, as treatment or advice can be provided quickly.

NBPH's Infectious Diseases Specialist has worked with Dr Dave Dixon on releasing posters and guidelines across General Practices, to support the reduction in reliance on antibiotics for mild to moderate cold and flu symptoms. This has been well received locally and has been reported within the media.

Individual antibiotic prescribing patterns have started to be fed back to individual GPs in simple totals format but with a plan to, in future, report if any unusual patterns are noted.

PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC

Only 7 Māori and 4 Pacific Island patients seen in clinics this year. Māori and Pacific Island patients have been included in external research projects and a Māori medical student was employed over the summer.

Rheumatology Specialist Service

PURPOSE A community based model of Rheumatology Specialist care for the management of people with complex inflammatory / rheumatoid conditions. To provide support and resources for primary care physicians.

OBJECTIVE

To provide a community based specialist service that:

- Provides patient centred care
- Meets the Ministry of Health expectations for Elective Services
- Addresses the follow-up appointment overdue list
- Achieve a timely follow up service
- Maintains a robust staffing level of clinicians providing regular clinics

PROGRAMME OVERVIEW

NBPH have been contracted by the DHB to provide a General Practitioners Special Interest (GPSI) orientated Specialist Rheumatology for the region. The service has undergone a number of challenges and changes in structure but is now adequately staffed with a satisfactory number of GP's involved as GPSI's and a newly retired Rheumatologist available to provide back up for Dr Porter, who is the Specialist Rheumatologist employed with this service.

PERFORMANCE

Contractual obligations had predominantly focussed on new patient appointments only, First Specialist Appointment (FSA) as this is a Ministry of Health key performance indicator. This focused approach, in conjunction with the absence of the Specialist and low GPSI numbers, resulted in an increased number of follow up appointment schedules that were not met. This was addressed with increased funding provided and since January 2017 there has been an increased number of clinics to address this issue and waiting times are now being reduced.

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

We have met the Elective Services Performance Indicators (EPSI) targets wherever possible. These are dictated by the Ministry of Health on a monthly basis but achievement has been difficult due to capacity issues and unavailability of a specialist. This has been mitigated with increased clinics and the addition of a locum specialist now being available for future clinics.

Maintaining appropriate follow up timeframes continues to be a risk issue, which is being monitored and addressed promptly.

REFERRAL TARGETS (YEAR):

Meeting ESPI targets and achieving timely follow up appointment timeframes are extremely important targets for this service. There is a 3-month expectation for a FSA and the follow up appointments are dependent on how quickly the client needs to be reviewed- either 3, 6, 9 or 12 months.

For this financial year:

MAORI HEALTH ACTIVITIES

39 Māori patients were seen in Nelson clinics. This is a 5% increase from last year. Numbers are not high but are indicative of the low numbers of inflammatory conditions requiring specialist input.

Golden Bay Community Health

Aged Residential Care

PURPOSE To provide residential aged care services at rest home level for the people over 65 years of age.

OBJECTIVE

The main objectives of the provision of aged residential care are:

- To provide a safe environment for individuals over 65 who have been assessed as needing assisted living accommodation.
- Enable individuals to continue with an active, healthy life with support from the healthcare team.
- Promote well-being with the over 65 age group through physical activity and social interactions.

PROGRAMME OVERVIEW

Golden Bay Community Health is funded by Nelson Marlborough District Health to provide 17 aged care residential beds in Golden Bay.

PERFORMANCE

The residential beds have been at 100% occupancy for the first 3 quarters of the financial year. The final quarter has seen a reduction of 2 occupied beds.

Regular audits of quality of care and incidences are completed, these are used to continually monitor and improve service deliver. Besides the internal audits, we are using Quality Performance Systems (QPS) benchmarking to review our performance on issues such as incidents of tears, pressure areas, use of restraints and polypharmacy against Australian standards. This is a new initiate but will allow us to compare our service delivery against international standards and develop continuous improvement tools based on our own experiences.

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Consistent occupancy of 100% for the majority of the year has been a great achievement that we aim to maintain in future years.

- Falls - well within acceptable norms for the industry
- Pressure areas – no hospital required pressure areas since Jan 2017
- Medication errors - have reduced considerably in the last year and are now well within the acceptable norms for the industry

INCIDENT REPORTS	YTD AVERAGE	NATIONAL
Falls	6	24
Pressure areas	0	1
Medication errors	1.5	2

- Occupancy 92.5 % average over 12 months
- Staffing: Aged Coordinator role developed. General: there has been a considerable (though) expected turn over but levels have now stabilised.

District Nursing

PURPOSE To provide home based nursing care to the population of Golden Bay who fulfil admission criteria.

OBJECTIVE

To ensure residents of Golden Bay who require expert nursing intervention can stay at home and receive a high standard of care.

PROGRAMME OVERVIEW

7 days/week nursing service providing:

- complex wound management
- palliative care
- other nursing interventions

PERFORMANCE

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Although the number of episodes of care has remained stable over the last two years, there has been a significant increase in the complexity of care required to keep people in their homes.

Patients with more complex wound management needs are being discharged into the community, requiring more skilled nursing interventions. These can be very time and cost intensive and require nurses to have access to regular in-service to ensure their competent.

The demands on the Palliative aspect of the District Nursing service have also increased significantly. Patients increasingly have more complex needs in relation to symptom management and end of life planning. Assisting in the development of Advanced Care plans is a time consuming and sensitive process.

Again access to regular in-service and networking is essential to maintain current service. Regular access to the Nurse Practitioner for Hospice is an important step in maintaining the competency of the service to Palliative patients.

MAORI HEALTH ACTIVITIES

Ethnicity data is currently not collected for all District Nursing admissions. Palliative admissions to the service do have ethnicity data collected and this indicates that the admissions for palliative care reflect the ethnicity of the general Golden Bay population.

Hospital Level Care

PURPOSE To provide Continuing care aged care services at Hospital level for the people over 65 years of age.

OBJECTIVE

The main objectives of the provision of Continuing aged care:

- To provide a safe environment for individuals over 65 who have been assessed as needing continuing care at hospital level
- Provide individuals with a safe environment, maintaining a good quality of life
- Promote well-being with the over 65 age group through assistance with all activities of daily living and encouraging social interaction

PROGRAMME OVERVIEW

Golden Bay Community Health is funded by Nelson Marlborough Health to provide 7 continuing care beds in Golden Bay.

PERFORMANCE

The continuing care beds have been at over 100% occupancy, with an average occupancy of 10 hospital level care residents and an additional hospital level care ACC patient.

OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

Consistent occupancy of 100% for the majority of the year has been a great achievement that we aim to maintain in future years.

PARTICIPANTS IDENTIFYING AS MAORI OR PACIFIC

One Māori hospital level care patient.

Midwifery Service

PURPOSE To provide midwifery services to the eligible population in the community of Golden Bay.

OBJECTIVE

The main objectives of the provision of Maternity services are:

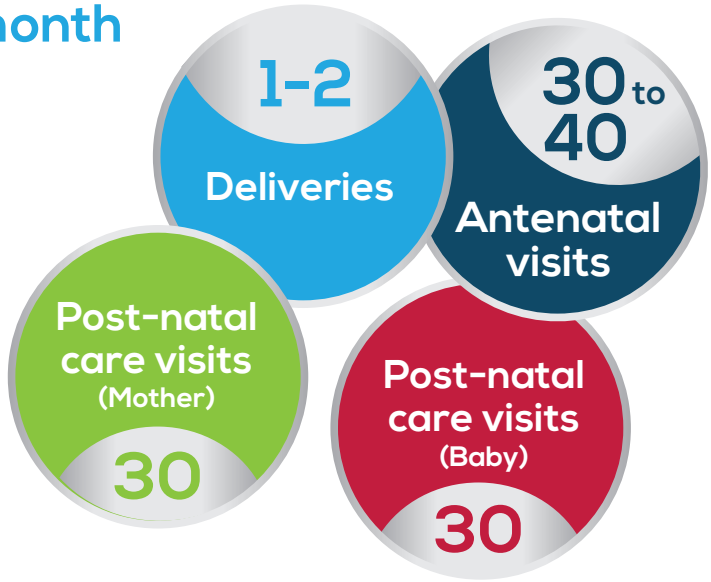
- Providing core midwifery support for in-patient care
- 24/7 on call services for pregnant women
- Baby Friendly Hospital services
- Ante-natal care for women in Golden Bay
- Home birthing services for women
- Birthing unit for women who choose to have their baby within the healthcare setting

PROGRAMME OVERVIEW

The midwifery service is delivered by three independent midwives in Golden Bay, all of which are registered with the Ministry of Health to practice as Lead Midwifery Carers.

PERFORMANCE

The midwifery service remains consistent and sees per month approximately:



K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The service continues to deliver safe and consistent practice to the women of the Golden Bay Community. It offers the opportunity for women to have their babies at home, or in the health facility.

Primary Care

PURPOSE To provide General Practitioner, Practise Nurse and phlebotomy services. The Rural Practice Services run from Monday – Friday and there is 24/7 after hour's urgent care services provided.

OBJECTIVE

To maintain healthcare services for the population of Golden Bay, the care delivery incorporates all ages of the population

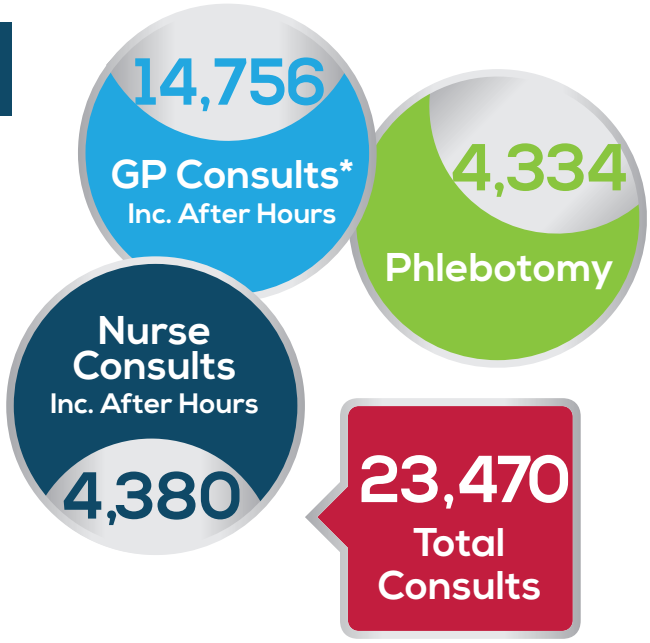
PROGRAMME OVERVIEW

- Routine GP services within the medical practice
- Health Promotion
- Diabetes screening
- Cardiovascular risk assessments
- Phlebotomy services, urgent and routine
- Occupational Health checks
- Medicals for Driving licence
- ACC acute and ongoing care

PERFORMANCE

The waiting times for an appointment have gone down from approximately 2 weeks to less than 2 days.

DNA (did not arrive) has decreased from over 10% of all consults to 1%.



* GP consults do NOT include ward rounds

MAIN QUALITY IMPROVEMENT PROJECTS

Medical record revamp

Medical records were kept in different areas by different service providers resulting in double ups. The main bulk of records were stored in a container in a way that had become unsafe to access and difficult to locate the required record.

A revamp took place (with financial support of NBPH). All current medical record for all services are now stored in one central place, in codafiles and sorted on NHI number in a way that is safe and easily accessible.

Resuscitation and triage

The triage system at Golden Bay Community Health has undergone a significant reorganisation to reduce waiting times, improve patient care and patient flow, and work satisfaction. The community were informed via 2 open-days, newspaper articles and meeting with community representatives.

The new triage system is successful:

- Waiting times have gone down from median 33 to 21 minutes
- The system is flexible enough to accommodate for increased demand in high/holiday seasons and less busy winter periods
- Community feedback is positive

Well Child Services

PURPOSE To provide well child services to the eligible population in the community of Golden Bay.

OBJECTIVE

The main objectives of the provision of Well child services are:

- Services for Children and Young People – Tier Level One
- Services for Children and Young People – School and Preschool Health Services – Tier Level Two
- Services for Children and Young People – Well Child / Tamariki Ora Services - Tier Level Two (please note this includes B4 School checks)

PROGRAMME OVERVIEW

The well child service is managed by a sole practitioner in Golden Bay with a defined support network consisting of the social work team, schools and midwives.

K.P.I OUTCOMES HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

The service continues to deliver safe and consistent practice to the younger population of Golden Bay and is an essential service for Mother's and children.

NELSON BAYS PRIMARY HEALTH GOLDEN BAY	Q1	Q2	Q3	Q4	TOTAL FOR YEAR
Total number of enrolled children at end of quarter	69	68	61	59	257
Number of new baby cases enrolled during quarter	15	14	13	16	58
Number of core contacts delivered during quarter	82	77	61	56	276
Number of Early Additional Contacts (EACs) delivered during quarter (antenatal to 122 days)					
• No. of antenatal contacts					0
• No. of face to face contacts		5	1	5	11
• No. of telephone contacts	11	20	13	5	49
• No. of contacts in group setting					0
• **Total EACs**	**11**	**25**	**14**	**10**	**60**
Number of Standard Additional contacts (SACs) delivered during quarter (122 days to five years):					
• No. of face to face contacts	9	18	25	22	74
• No. of telephone contacts	33	71	64	34	202
• No. of contacts in group setting	2	8	2	2	14
• **Total SACs**	**44**	**97**	**91**	**58**	**290**

Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

NELSON BAYS PRIMARY HEALTH TRUST

Financial Reports

for the year ended 30 June 2017

Nelson Bays Primary Health Trust

Summary Statement of Financial Performance

for the Year Ended 30 June 2017

	2017 $	2016 $
REVENUE		
Exchange		
Patient fees	755,785	889,324
Non-Exchange		
Management Services	862,681	891,757
Share of profit/(loss) from Joint Venture - Health Systems Solutions Limited	6,361	9,938
Share of profit/(loss) from Joint Venture - Medical and Injury Centre Limited	5,104	35,934
Primary Care Contract Services	23,190,991	22,403,483
Other	4,203,246	3,527,968
Total Revenue	**29,024,168**	**27,758,404**
LESS EXPENSES		
Accounting and Audit	27,274	36,046
Office & Organisation Expenses	1,474,855	1,775,607
Board Expenses	75,767	86,768
Staffing Expenses	1,118,141	1,339,761
Primary Care Services	20,388,288	20,000,062
Other Costs	5,192,644	5,103,028
Total Operating Expenses	**28,276,969**	**28,341,272**
NET SURPLUS	**747,199**	**(582,868)**

Nelson Bays Primary Health Trust

Summary Statement of Movements in Equity

for the Year Ended 30 June 2017

	2017 $	2016 $
Net surplus for the year	747,199	(582,868)
Total recognised revenues & expenses	**747,199**	**(582,868)**
Committed Funding Reserve	1,889,682	2,075,224
Retained Earnings	899,204	1,296,530
Opening Equity	**2,788,886**	**3,371,754**
Committed Funding Reserve	2,349,506	1,889,682
Retained Earnings	1,186,579	899,204
Closing Equity	**3,536,085**	**2,788,886**

NOTE:	**2017 $**
The composition of the net surplus is as follows:	
Committed Funding Reserve. Representing contract funding to be applied to future commitments of those contracts rolling over.	459,824
Share of profit/(loss) from Joint Venture and interest received	97,183
Remaining surplus	190,192
NET SURPLUS	**747,199**

This Statement has been prepared on the basis as described on page 3

Nelson Bays Primary Health Trust
Summary Statement of Financial Position
as at 30 June 2017

	2017 $	2016 $
CURRENT ASSETS		
Cash at Bank & Investments	3,865,284	2,790,280
Receivables and Prepayments	1,140,941	1,140,456
Total Current Assets	**5,006,225**	**3,930,736**
CURRENT LIABILITIES		
Payables	1,206,180	1,006,896
Employee benefits	736,395	638,458
Total Current Liabilities	**1,942,575**	**1,645,354**
WORKING CAPITAL	**3,063,650**	**2,285,382**
NON-CURRENT ASSETS		
Plant, Property & Equipment	595,127	605,848
TERM LIABILITIES	**122,692**	**102,344**
NET ASSETS	**3,536,085**	**2,788,886**
Represented by:		
Committed Funding Reserve	2,349,506	1,889,682
Retained Earnings	1,186,579	899,204
EQUITY	**3,536,085**	**2,788,886**

13 September 2017

Trustee: John Hunter

Trustee: Sarah Green

Nelson Bays Primary Health Trust
Summary Statement of Cash Flows
for the Year Ended 30 June 2017

	2017 $	2016 $
Net cash flows from operating activities	1,228,002	(380,071)
Net cash flows from investing activities	(1,480,926)	74,928
Net increase / (decrease) in cash and cash equivalents	**(252,924)**	**(305,143)**
Cash and cash equivalents at beginning of period	1,297,389	1,602,532
Cash and cash equivalents at end of period	1,044,465	1,297,389

Nelson Bays Primary Health Trust
Notes to the Summary Financial Statements
for the Year Ended 30 June 2017

The summary financial statements for Nelson Bays Primary Health Trust for the year ended 30 June 2017 have been extracted from the full financial statements. The full financial statements were approved by the Board on 13 September 2017. The full financial statements were prepared in accordance with New Zealand Generally Accepted Accounting Practice ("NZ GAAP"). NZ GAAP, in the case of Nelson Bays Primary Health Trust, means Public Benefit Standards Reduced Disclosure Regime ("PBE Standards RDR"), as appropriate for Tier 2 not-for-profit public benefit entities. The summary financial statements are in compliance with PBE FRS 43 – Summary Financial Statements and are presented in New Zealand dollars and rounded to the nearest dollar.

The summary financial statements cannot be expected to provide as complete an understanding as provided by the full financial reports. A copy of the full financial reports can be obtained by contacting Nelson Bays Primary Health.

No material events have occurred subsequent to the reporting date that require disclosure or adjustments to be made to the 30 June 2017 financial statements. (2016: none)

The auditor BDO Wellington has reviewed the summary financial statements for consistency with the audited full financial statements. An unmodified audit opinion has been issued. These summary financial statements have been approved for issue by the Board of Nelson Bays Primary Health.

BDO WELLINGTON

INDEPENDENT AUDITOR'S REPORT ON THE SUMMARY FINANCIAL STATEMENTS TO THE TRUSTEES OF NELSON BAYS PRIMARY HEALTH TRUST

The accompanying summary financial statements, which comprise the summary statement of financial position as at 30 June 2017, and the summary statement of comprehensive revenue and expense, summary statement of changes in equity and summary statement of cashflows for the year then ended, and related notes, are derived from the audited financial statements of Nelson Bays Primary Health Trust for the year ended 30 June 2017. We expressed an unmodified audit opinion on those financial statements in our report dated 13 September 2017.

The summary financial statements do not include all the disclosures included in the financial statements. Reading the summary financial statements, therefore is not a substitute for reading the audited financial statements of Nelson Bays Primary Health Trust.

The Board's Responsibility for the Summary Financial Statements

The Board is responsible for the preparation of a summary of the audited financial statements in accordance with FRS-43: *Summary Financial Reports* ("FRS-43").

Auditor's Responsibility

Our responsibility is to express an opinion on these summary financial statements based on our procedures, which were conducted in accordance with International Standard on Auditing (New Zealand) (ISA (NZ)) 810 (Revised, "Engagements to Report on Summary Financial Statements".

Other than in our capacity as auditor we have no relationship with, or interests in, Nelson Bays Primary Health Trust.

Opinion

In our opinion, the summary financial statements derived from the audited financial statements of Nelson Bays Primary Health Trust for the year ended 30 June 2017 are consistent, in all material respects, with those financial statements in accordance with FRS-43.

Who we Report to

This report is made solely to the Trust's trustees, as a body. Our audit work has been undertaken so that we might state those matters which we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's trustees, as a body, for our audit work, for this report or for the opinions we have formed.

BDO Wellington

BDO Wellington
13 September 2017
Wellington
New Zealand

Everyone working in unison to achieve the vision

Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Kia piki te ora o ngā tāngata katoa