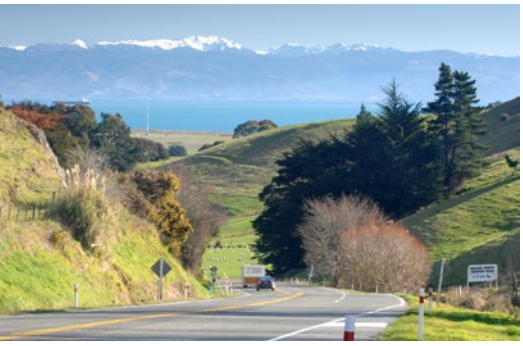
Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere









Annual Report

1 JULY 2017 – 30 JUNE 2018

Healthy People | Healthy Workplace | Healthy Community

Our Region

RICHMOND/WAKEFIELD PRACTICES

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

NELSON PRACTICES

Harley Street 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
Tima Health
Titoki Medical
Toi Toi Medical Centre

MAPUA/MOTUEKA/ GOLDEN BAY PRACTICES

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

MARLBOROUGH

Renwick Medical Centre

Contents

continues over...

Contents

HEALTH SERVICES *continued*

HEALTH SERVICES

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 also, in conjunction with the local community and other health care providers, targeted programmes which aim to improve and maintain good health of our population 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 21 General Practices currently contracted to Nelson Bays Primary Health.

NELSON
Harley Street 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
Titoki Medical
Toi Toi Medical

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

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' and one General Practice with 'Access' (low cost for Community Services Card holders).

He Mihi

He hōnore, he korōria ki te Ātua
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 Ātiawa, Ngāti Tama, Ngāti Kuia, Ngāti Koata, Ngāti Rārua, Ngāti Toarangatira.

Ko te kaupapa Nelson Bays Primary Health, Pūrongo-a-Tau 2017/18 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 2017/18, 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 ngā 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

A. Support healthy living in the home
B. Ensure health information is accessible and understandable
C. Promote and support strong clinical governance and leadership
D. Ensure service planning and include consumer and community involvement
E. Ensure legal obligations are adhered to

PARTICIPATION HEALTHY WORKFORCE

A. Implement best practice governance, cultural competency and management
B. Work in partnerships to avoid duplication of services
C. Enable our workforce to operate at the top of their scope
D. Ensure sustainable and high quality service provision across the region
E. Focus on prevention, early detection and self-management to reduce disease progression

PARTNERSHIP HEALTHY COMMUNITY

A. Work in partnership with our key communities to ensure an inclusive whole-of-system approach
B. Address inequalities and gaps in services, particularly for our most vulnerable and high needs populations
C. Achieve all relevant health targets and indicators
D. Support evidenced-based models of care that have proven health outcomes

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 (NBPH) 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

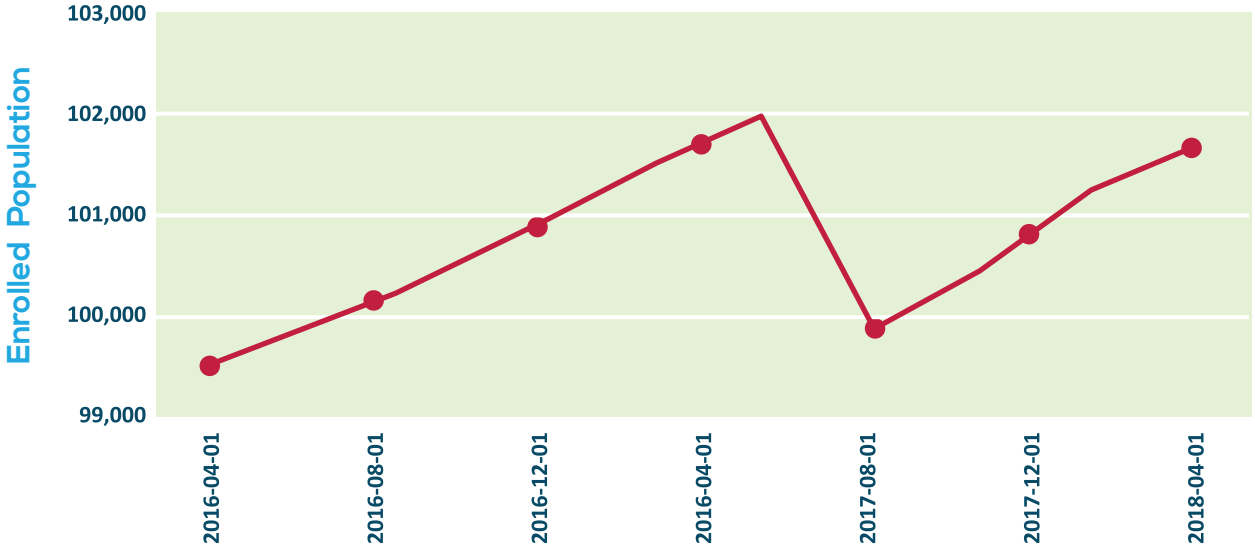
OUR GUIDING PRINCIPLE **People are our most valuable asset, they are our physical wealth and a reflection of our physical and spiritual health. We must empower, develop, value and retain them.**

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

Nelson Bays Enrolled Population

NELSON BAYS PRIMARY HEALTH POPULATION

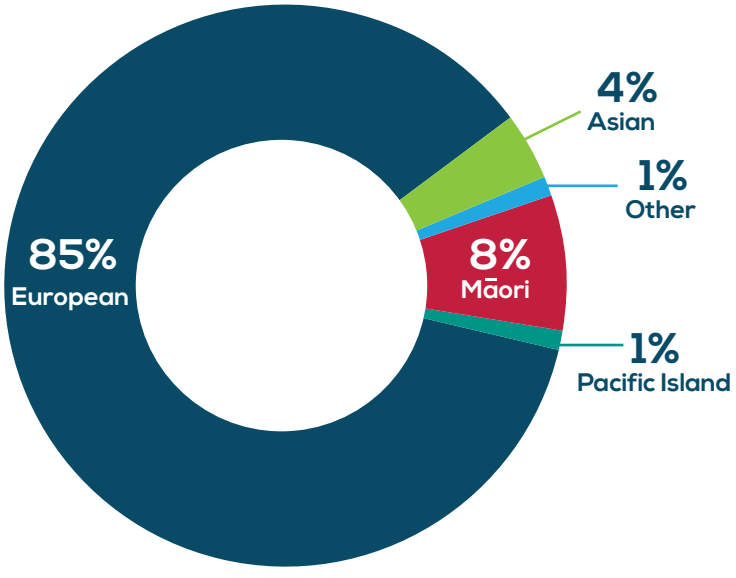
QUARTER	TOTAL POPULATION	% CHANGE
2018-07-01	101,727	0.46%
2018-04-01	101,258	0.78%
2018-01-01	100,476	0.58%
2017-10-01	99,900	-2.05%
2017-07-01	101,989	0.47%
2017-04-01	101,507	0.56%
2017-01-01	100,940	0.52%
2016-10-01	100,420	0.47%
2016-07-01	99,954	–



At the end of June 2018 101,727 people were enrolled with Nelson Bays Primary Health

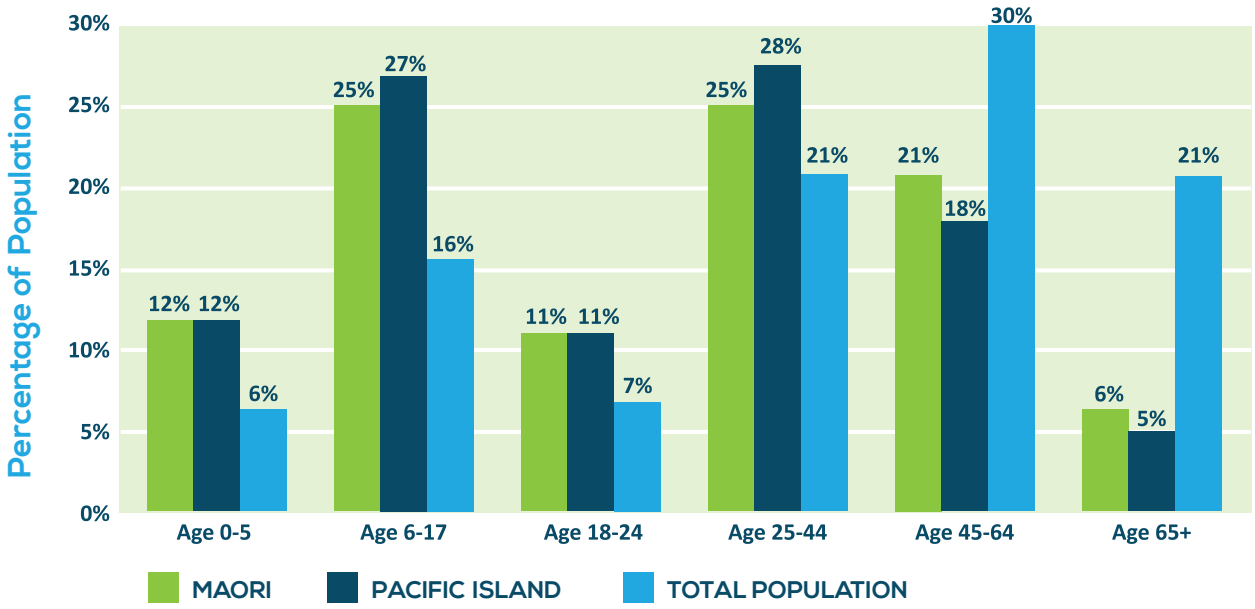
ETHNICITY

ETHNICITY	NUMBER	PERCENTAGE
Māori	8,569	8%
Pacific Island	1,273	1%
European	86,648	85%
Asian	3,773	4%
Other	1,464	1%
TOTAL	**101,727**	**100%**



Nelson Bays Enrolled Population

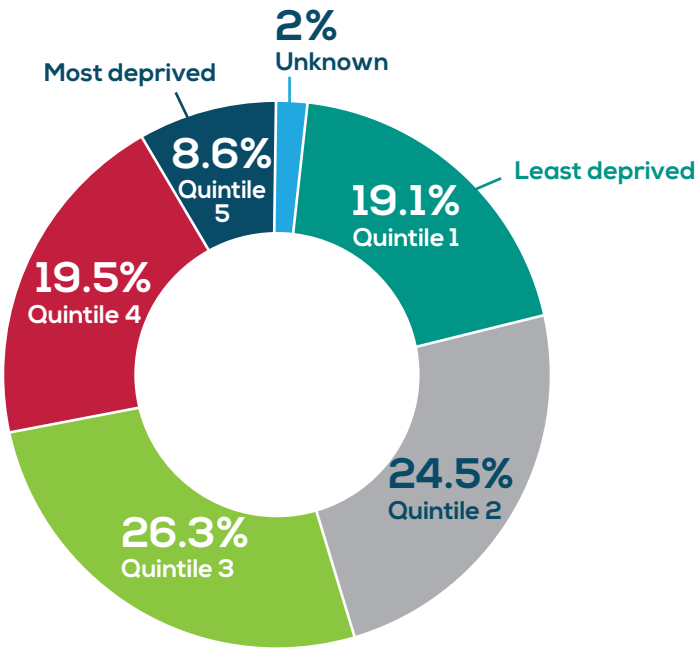
AGE GROUP PERCENTAGE OF POPULATION



AGE	MAORI	PERCENTAGE	PACIFIC ISLAND	PERCENTAGE	TOTAL POPULATION	PERCENTAGE
00-05	1045	12%	148	12%	6336	6%
06-17	2179	25%	344	27%	15986	16%
18-24	932	11%	138	11%	6755	7%
25-44	2117	25%	357	28%	20861	21%
45-64	1758	21%	224	18%	30489	30%
65+	538	6%	62	5%	21300	21%
TOTAL	**8,569**	**100%**	**1,273**	**100%**	**101,727**	**100%**

DEPRIVATION BY QUINTILE

QUINTILE	NUMBER	PERCENTAGE
Unknown	2,053	2.0%
1 (Least deprived)	19,439	19.1%
2	24,947	24.5%
3	26,742	26.3%
4	19,828	19.5%
5 (Most deprived)	8,718	8.6%
TOTAL	**101,727**	**100.0%**



Chair's Report

> *... One of the key investments that we have commenced and intend to progress in the forthcoming year is the Health Care Home initiative.*

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 2018.

This Annual Report highlights the services that our Primary Health Organisation has provided to the community over the last financial year. The reporting continues the efforts towards evidenced-based reporting which tracks health outcomes over time. I invite you to read the report which demonstrates the ways in which we improve the lives of all those in our community.

BOARD MEMBERS 2017-2018

John Hunter
CHAIR

Sarah Green
DEPUTY CHAIR
PROVIDER REPRESENTATIVE

Philip Chapman
COMMUNITY REPRESENTATIVE

Stuart Hebberd
PROVIDER REPRESENTATIVE

The strength of our Primary Health Organisation is demonstrated by the balance sheet in the Financial Statements at the end of the Annual Report. Our retained earnings now stand at a level which enables us to invest in new unfunded services into the future and to withstand unexpected events that affect us from time to time. The committed funding reserves represents cash received in advance in respect of health services yet to be delivered.

One of the key investments that we have commenced and intend to progress in the forthcoming year is the Health Care Home initiative. This initiative has the objectives of addressing some of the challenges faced by General Practice, being:

- Ready access to urgent and unplanned care
- Proactive care for those with more complex need
- Improved routine and preventative care
- Improved business efficiency and sustainability

This initiative is a primary care model that gives patients more control, the practice team an environment where quality of care and innovation can flourish and enables proactive, coordinated care for those that need it most.

This initiative, has been implemented in 128 General Practices throughout New Zealand, with increasing evidence that it has great primary health benefits to both the community and General Practices. Angela (our Chief Executive) and I look forward to the implementation of this in the coming year.

The Golden Bay Community Health facility continues to make progress, though not without its challenges. Whilst community trust and support continues to increase and the facility is now financially viable, the lack of permanent General Practitioner staff has posed challenges which are in part being addressed by the recruitment of a Nurse Practitioner along with revised models of care. Ongoing effort is being put into the international search for our full complement of doctors.

Once again, I'd like to thank the groups of people without whom our Primary Health Organisation would be unable to function. These include the Board who give their time and experience out of a sense of civic duty; Angela Francis our 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 Primary Health Organisation and lastly (but not least) our community for which we serve.

Ngā Mihi,

John Hunter
CHAIR

Helen Kingston
COMMUNITY REPRESENTATIVE

Lisa Lawrence
IWI/MĀORI REPRESENTATIVE

Kim Ngawhika
MĀORI REPRESENTATIVE

Sue Stubbs
PROVIDER REPRESENTATIVE

Chief Executive's Report

> *... I would like to acknowledge and thank our staff, without you our achievements would not have been possible.*

Kia Ora Koutou,

It has been a year of challenge and a year of change for Nelson Bays Primary Health. This report highlights some of our achievements over the last 12 months, towards achieving our vision of "healthy people... healthy workforce... healthy community".

Over the last year, some of the challenges within General Practice included:

- Ageing population bringing increased demand, and the need for resource reallocation between services
- Increasing risk (including lifestyles), incidence and complexity of long term conditions
- Increased ethnic diversity – refugees and migrants
- Persistent inequalities in access and outcomes for the most vulnerable in our community

Therefore, Nelson Bays Primary Health continued to focus on:

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

The above approach resulted in a refinement of service design and delivery resulting in enhanced health status for the population as demonstrated throughout this report. It also emphasised the need for ongoing collaboration with our key partners.

A collaborative approach with Marlborough Primary Health and Nelson Marlborough Health not only resulted in a joined–up approach working towards health system integration (Models of Care) instigated by Nelson Marlborough Health but also the formation of a district-wide Health Care Home collaboration with a facilitator being appointed, project plan developed and steering group formed. In addition, a joint approach adopted for service design/delivery across the district resulted in Nelson Bays Primary Health and Marlborough Primary Health sharing joint appointments for example the Director of Nursing role. Bi-annual joint Board meetings were conducted and a one contract/service approach was implemented where it made sense to do so.

Additional Nelson Bays Primary Health achievements include:

- 90% of our General Practices achieving Cornerstone accreditation with the remaining 10% achieving foundation standards
- New strategic priorities to support Nelson Bays Primary Health's most vulnerable populations were implemented, for example the recruitment of Nelson Bays Primary Health's Social Worker within the Kaiatawhai service along with the appointment of a Mental Health Nurse Practitioner (joint role with Marlborough Primary Health) and Mental Health Navigator
- A Youth Health Hub developed for Golden Bay and supported by Nelson Bays Primary Health's Youth Alcohol and Drug Clinician
- Nelson Bays Primary Health provided a variety of services for our Golden Bay Community including a revised acute model of care being implemented. Cost efficiencies were subsequently created resulting in a break-even year-end result
- The annual Stakeholder Satisfaction Survey highlighted a continued improvement trend across the key areas, evidenced by an increase in neutral or positive responses for Nelson Bays Primary Health meeting respondent expectations (93.9% in 2018 vs 88.4% in 2017)
- The annual staff satisfaction survey highlighted that 9 out of 10 themes scored 4 or more out of six, with the remaining theme reporting marginal improvement. Three themes reported an upward trend for the third year in a row
- Staff turnover rates were low, evidenced by monthly results consistently tracking below New Zealand national average (all industries combined) and 8-10% below healthcare industry rate
- All required savings were achieved as demonstrated in the financial report 2017/18 year
- Nelson Bays Primary Health programmes and services highlighted achievement against all contracted revenue and targets as evidenced throughout this report

In closing, I would like to acknowledge and thank our staff; without you our achievements would not have been possible. Thanks also to our key partners including our General Practice teams, Marlborough Primary Health, Nelson Marlborough Health and our community providers. I would also like to acknowledge the Nelson Bays Primary Health Board for their ongoing support throughout the last 12 months.

Ngā Mihi,

Angela Francis
CHIEF EXECUTIVE

Clinical Governance Committee Chair's Report

The Nelson Bays Primary Health Clinical Governance Committee (CGC) met regularly over the 2017/18 year. The Committee has representation from General Practitioners and Practice Nurses, Practice Managers, Pharmacy, Māori health, as well as the Board, Management and Nelson Marlborough Health. We also have a Consumer Representative on the Committee.

The CGC has a role in overseeing the clinical quality of services that are provided under Nelson Bays Primary Health and as an advisory committee to the Nelson Bays Primary Health Board. The CGC aims to apply a quality lens over services alongside Te Tumu Whakaora who apply their Māori health lens.

Over the past year, the Committee has considered initiatives including:

- Advanced Care Planning and how to encourage this across the appropriate population
- Bowel Cancer screening programme about to commence in August 2018
- The Patient Experience Survey, which is a quarterly online questionnaire administered to patients via our General Practices by the Health Quality and Safety Commission (HQSC). The survey results help to inform General Practices, the District Health Board, Government and ourselves (Nelson Bays Primary Health), in quality improvement activities aimed at improving patient outcomes
- The establishment of standardised 'Standing Orders for Nurses' on Health-Pathways. This work is crucial for upskilling primary care nurses to work at the top of scope, freeing Doctors for more complex work and improving access to care for patients
- Moving suitable services from secondary care into primary care, with appropriate resources. Examples have been spirometry, more advanced skin lesion surgeries, and soon iron infusions

The CGC is also considering and watching with interest the introduction of the 'Health Care Home' model of care in General Practices. This model looks at new ways of working via the domains of urgent and unplanned care, proactive care, routine and preventive care, and business efficiency. It explores the greater use of technologies, and a wider team in General Practice that might include the Community Pharmacist, Social Worker, Dietitian, Health Coach, Counselling etc.

Our Clinical Governance Committee Chair continues to share key messages, and to meet periodically with the chairs of 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.

Sue Stubbs
CLINICAL GOVERNANCE COMMITTEE CHAIR

Te Tumu Whakaora Chair's Report

In my final year as a Board Trustee for Nelson Bays Primary Health it gives me great pleasure to present this report on behalf of Te Tumu Whakaora. Te Tumu Whakaora was able to support Nelson Bays Primary Health services to further develop and improve their responsiveness to Māori.

Highlights include:

- Maintaining the focus on Māori who are for all intents invisible in the current Ministry of Health 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 and encouragement of a collaboration to study Te Tau Ihu specific Rongoa Māori by Nelson Bays Primary Health's Infectious Disease Specialist Dr Richard Everts, Cawthron Institute and local Māori medical students

I have the utmost appreciation of the work undertaken by our members, 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. Nelson Bays Primary Health still has so much to do and we must press for progress. The organisation has a number of things in place to support improvement:

- A clear directive in service contracts that Māori health needs and service delivery are shaped and planned at the beginning of service development
- A Māori health plan that sits alongside the strategic plan
- Te Tumu Whakaora being a dedicated space for reflection and support to progress engagement strategies with and for, Māori

I encourage all staff and trustees to activate their professional interest in Te Ao Māori to include te reo me ona tikanga. The importance of having an overall coordinated approach throughout all levels of the organisation will make sure resources are directed when and where they are needed. Mauri ora!

Lisa Lawrence
TE TUMU WHAKAORA CHAIR

Our Team

Everyone working in unison to achieve the vision

Joint Ventures

HEALTH SYSTEMS SOLUTIONS

Health Systems Solutions Limited is a collaboration between the shareholding entities Nelson Bays Primary Health, WellSouth Primary Health Network, Rural Canterbury Primary Health Trust and Karo Data Management Limited, with other South Island Primary Health Organisations 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 Primary Health Organisations, representing an enrolled population of approximately 540,000 people.

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

PROGRESS

Over the 2017/18 financial year, Health Systems Solutions worked on consolidating and improving their products and rolling out a new version of their flagship product, Halcyon.

Health Systems Solutions offers the following products:

- Full Primary Health Organisation claims management system, including web portal for general practice, pharmacies, podiatrist and other providers to submit their claims, and a completely revised Primary Health Organisation 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 by Health Systems Solutions:

- Fully transitioned three separate Mental Health Services in the Otago/Southland region onto one consolidated database platform, providing an easy to use interface for managing all aspects of Brief Intervention Referrals
- Became an authorized provider of PRIMHD reporting to the Ministry of Health from their Mental Health Brief intervention service patient management system
- Developed a large number of new claiming programmes and forms including; a Comprehensive Health Assessment, Equally Well claim, Falls and Fracture Assessment, Diabetes Care Improvement, Bowel Screening, Ministry of Social Development Enrolment, General Practitioner Special Interest Intermediate Skin Lesion, Chronic Obstructive Pulmonary Disease Ambulance Diversion and Zostavax

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

Joint Ventures

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 of Nelson Hospital on 98 Waimea Road, Nelson.

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 2018, there were 26,686 patients seen compared to 24,348 patients seen the previous year
- The Medical and Injury Centre has continued and expanded the pilot with Nelson Marlborough Health to work even closer with the Emergency Department, so that patients are seen by the appropriate service and long waiting times can be avoided
- Nurses are trained to initiate minor limb injury x-ray requests to improve patient flow and reduce waiting times
- The Nurse Practitioner position has been increased to manage people's health needs in collaboration with other health care professionals
- The Nelson Bays Primary Health Social Worker is available for community visits or appointments within the Medical and Injury Centre clinic
- The Medical and Injury Centre has maintained both Cornerstone and Urgent Care Accreditation

Health and Safety Workforce

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

DURING 2017/18:

- Committee meetings were held at least bi-monthly, on each site
- Robust Health and Safety incident reporting, investigations and management occurred with the online reporting system
- Successful on-the-job health and safety training specific to individual roles and responsibilities was held
- Regular identification of hazards and management of the identified hazards were supported by the Health and Safety Committees, management and facility users
- Health and Safety Committee involvement contributed to the ongoing maintenance and updating of all Health and Safety policies, procedures and documentation, including the two sites Business Continuity Plans and Emergency Management Plan

EMPLOYEE AND WORKFORCE

Our Workforce as at 30 June 2018

One measure of a healthy and stable workforce is to look at staff departure (turnover) rates in comparison to national averages in the same industry. Nelson Bays Primary Health has a very low staff turnover rate, with 9.5% achieved to year end 30 June 2018. This compares admirably with the average annual staff turnover rate of 15.6% reported for health care providers across New Zealand* indicating team stability and an ability to embed knowledge and skill depth across our team.

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

158 Employees = **105** based at Golden Bay + **53** based in Richmond

- 17% are full time employees
- 83% are part time or casual employees

2018 ratings show that our organisation continues to go from strength to strength, with results even better than reported in the previous year

EMPLOYEE ENGAGEMENT

The annual Employee Workplace Satisfaction Survey was completed in February 2018. This tool checks the internal health of our own organisation, as employees rate their level of satisfaction with Nelson Bays Primary Health as an employer. The 2018 ratings show that our organisation continues to go from strength to strength, with results even better than reported in the previous year.

- ✓ An increase in overall staff satisfaction ratings were reported when compared to last year
- ✓ The most positive ratings since 2013 were again achieved in workplace survey themes
- ✓ A remarkable 91.2% of the survey questions satisfaction ratings were positive, achieving scores 4 or higher out of 6

The Top Three positively rated workplace themes in 2018 were:

1. My Team
2. Common Purpose
3. My Job

The dedication of our teams to their work, our organisation and to the community we serve remains evident.

*Source: The New Zealand Staff Turnover Survey 2017, Lawson Williams in partnership with Human Resources Institute of New Zealand.

Key Relationships

Nelson Bays Primary Health's 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.

IWI

The Chief Executive has undertaken visits to each iwi in our region to maintain a proactive 2-way relationship and support awareness-raising of Nelson Bays Primary Health's role and work underpinned by Nelson Bays Primary Health's Treaty obligations. This action supplements the direct cultural engagement activities undertaken by the representatives on the Nelson Bays Primary Health Board as well as the activities of Nelson Bays Primary Health's Tikanga Advisor and Kaumatua. Emerging engagement with individual Iwi was felt to be positive and proactive. This also provides opportunities for development of programmes that best fit the needs of their whānau along with an improved understanding of where Nelson Bays Primary Health needed to modify service design.

GENERAL PRACTICES

The Chief Executive has undertaken bi-annual visits to each General 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 Nelson Bays Primary Health Board level and associated clinicians (such as the chair of Clinical Governance Committee/Clinical Director and supporting clinical champions on Nelson Bays Primary Health committees and working groups). This has proved effective as demonstrated by the stakeholder feedback in the recent stakeholder survey. From these visits, Nelson Bays Primary Health gained valuable insight on the community needs from the General Practice perspective and was able to focus on promoting improved outcomes within its wider circle of influence.

COMMUNITY GROUPS

In addition to the valued groups mentioned previously, the Chief Executive and management undertook a programme of community group visits/meetings. The purpose of these meetings was to raise awareness of the role and objectives of Nelson Bays Primary Health to hear and listen about issues or concerns these groups have and to strengthen relationships with these vital members of the extended community.

In addition, Management took all opportunities to attend relevant community meetings to ensure a high profile and two-way dialogue with our enrolled population (this specifically included remote communities such as Collingwood). This action supplemented the specific community engagement work undertaken by Nelson Bays Primary Health Board of Directors.

Community groups visited included:

- Over 70 community older adult exercise groups have been visited and awarded the 'tick of approval' i.e. meets MoH, HQSC and ACC criteria for community falls prevention
- Involvement in the Positive Aging Forums including the Positive Ageing "Age to Be" Expo (with over 2,000 participants), Age Concern Nelson Tasman; Senior Volunteers Programme; Age Connect community workshop on self-neglect & social isolation within our ageing population
- Refugee and Migrant Resettlement Group; Red Cross Refugee Services orientation programme; Newly arrived quota refugee welcome functions; official opening of the Red Cross office in Tahunanui; Ministry of Business Innovation and Employment (MBIE) regional meetings for refugee and migrant updates
- Nelson Marlborough Falls Alliance Group meetings facilitated by Nelson Bays Primary Health – membership includes: Nelson Marlborough Health, Nelson Bays Primary Health, Marlborough Primary Health, ACC, St John Ambulance, Telehealth reps, Community Pharmacy, Gerontologists, Allied Health, Nurse Practitioner (primary care)
- Nelson Tasman Pacific Community Trust, worked in partnership to develop and deliver Diabetes Education sessions. Three sessions delivered reaching over 200 Pacific people
- Te Piki Oranga, regular meetings with General Manager and Nurse Managers at Whakatu and Te Āwhina, to foster better communication between Nelson Bays Primary Health and Te Piki Oranga. Recent meeting discussed progress on cervical smears and the offer of free Heart and Diabetes Check vouchers, along with support to develop a Te Piki Oranga Facebook page advert
- Other Community Groups visited include: MenzShed regional forum; Community and Whanau Meetings across the district; Nelson Tasman Hospice Board Meeting; Tongan Community Trust; Teen Health Fest; Heart Foundation; Motueka Family Service Centre; Nelson Women's Centre; Workbridge; Family Start; Barnardos; Nelson Women's Refuge; Kai Rescue; Nelson Tasman Housing Trust; Salvation Army; Anglican Support Services; St Vincent De Paul; YMCA; Age Concern Nelson Tasman; Grey Power Nelson; Positive Ageing Forum

NELSON BAYS PRIMARY HEALTH CONTESTABLE FUNDING POOL

Nelson Bays Primary Health has two contestable funding pools that community groups may apply through to secure small amounts of funding. These are:

1. Community Initiative – To financially support new Health Promotion initiatives within the community, on successful application. Community Initiatives grants of up to $1,000 are awarded to successful applicants. There were five successful applications awarded this year
2. Workforce Development – To financially support community or volunteer organisations to undertake health promotion staff training on successful application. Workforce Development grants of up to $500 are awarded to successful applicants. There were nine successful applications awarded this year

Key Relationships

NELSON BAYS PRIMARY HEALTH COMMUNITY SUB-CONTRACTS

There are also community organisations that Nelson Bays Primary Health has direct contracts with for more specific initiatives. These include contracts with:

- Red Cross Refugee services – for quota refugee interpretation and translation services
- Victory Community Centre – for Health Navigator services
- Nelson Tasman Pacific Community Trust – for Pacific Health Navigator service
- Whanake Youth – for Targeted Youth Health Service
- Nelson Asthma Society – for respiratory rehabilitation and Asthma promotion and prevention services
- Age Concern Nelson Tasman – for Community and Whānau facilitator services
- Mapua Podiatry – for a specialist podiatry service linked to diabetes foot complications

Funding recommendations as always, are based on available funding.

NELSON BAYS PRIMARY HEALTH ANNUAL GENERAL MEETING ATTENDEES

At the 2017 Annual General Meeting it was pleasing to note the level of interest and engagement with many of our community groups.

STAKEHOLDER SURVEY RESULTS (1 JULY 2017 – 30 JUNE 2018)

The Stakeholder survey was distributed to community groups, some of whom are mentioned above. This is an electronic survey where we measure the impact our organisation has on these groups. It is also a great opportunity to implement a quality improvement process. Key findings from the survey are below.

The majority of respondents (84%) had contact or made use of Nelson Bays Primary Health services on four or more occasions in the last year. This is an increase when compared to 2017 results of 79.6%.

As with previous survey results, the 2018 survey indicated positive results in the majority of the areas:

- An increased use of Nelson Bays Primary Health support and services across seven areas. This includes a marked increase in use of resources, information, financial support and administration support
- The majority (51%) confirm their expectations are being met for the support and service provided by Nelson Bays Primary Health, with a positive trend reflected year on year. Conversely, fewer respondents (6.1%) indicated their expectations were not met in 2018, an improvement on previous year results (11.5% in 2017)
- When asked to compare to one year ago the vast majority (92.5%) of respondents felt that Nelson Bays Primary Health was similar or had improved in the last year. This was an increase on 71.7% in this category reported in 2017
- Conversely, only 7.5% of respondents in 2018 rated Nelson Bays Primary Health as being slightly worse than one year ago, compared with 28.4% of respondents rating Nelson Bays Primary Health as slightly or much worse for this question in 2017. This is a marked improvement in stakeholder perception results in 2018

When asked about satisfaction levels by location, the majority of respondents indicated they were somewhat or very satisfied with the service and support provided by both Richmond (69.77%) and Golden Bay (66.7%) locations.

In 2018 the largest portion of survey respondents (54.7%) were in General Practice, as had been the case in 2017 (39.8%). Worthy of note is the strong participation rate from community organisations remaining evident in 2018, with 22.6% of respondents representing this sector. This Community representation has grown from a modest level of 15.2% in the 2016 survey.

Overall it is apparent that Nelson Bays Primary Health is recognised by stakeholders as being on the right path in 2018. This has been evidenced by:

- The improvement in ratings given for expectations being met vs 2017
- The majority of respondents indicating their satisfaction with support and service at both Golden Bay and Richmond locations
- Stakeholders wanting more support and services along the same lines of what has already been noted as valued and appreciated

Health Services

Health Promotion Services

Community Cardiac Rehabilitation Healthy Hearts

PURPOSE To support recovery from a heart event or procedure that required hospital admission, and aimed at slowing or reversing complications of established cardiovascular disease. The overall purpose is to reduce the second heart attack. (i.e. secondary prevention).

OBJECTIVE

- Improve the patient and their families knowledge of cardiovascular disease
- Improve confidence to be able to recognise and respond to symptoms
- Promote medication adherence following a heart event
- Reduce unplanned cardiac related Emergency Department presentations
- Increase long-term lifestyle modifications that improve health outcomes

PROGRAMME OVERVIEW

Nelson Bays Primary Health deliver a community-based Cardiac Rehabilitation and self-management programme in partnership with the cardiology team at Nelson Marlborough Health. A referral is sent on discharge from hospital if the patient agrees. Staff at Nelson Bays Primary Health respond to the referral by offering an invitation to attend. Two delivery options are available for patients and their family to attend:

- **Healthy Hearts** – a one-off 6 hour group education session held in the community. Sessions can be split into two half days if preferred (usually offered to those following surgery)
- **Heart Guide Aotearoa** – home-based work-book option with telephone support and follow up

Healthy Hearts sessions are co-presented with the green prescription team, community pharmacist, primary care dietitian and cardiac nurse specialists. All patients attending receive three postal questionnaires over a 12 month period to monitor outcomes.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Referrals				
• Numbers referred	152		283** ***Includes 50 x Marlborough referrals as no regional service available*	
• Ethnicity	**Māori** 10	**Non-Māori** 142	**Māori** 13	**Non-Māori** 270
Heart Guide Aotearoa				
Number of referrals choosing this option	3		8	
Healthy Hearts				
• Total Number of Healthy Heart sessions delivered	11		13	
• Number of patients attended	88		136	

Community Cardiac Rehabilitation Healthy Hearts

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Healthy Hearts				
• Gender of those attending	**Male** 70	**Female** 18	**Male** 102	**Female** 34
• Age range of those attending	**Under 65yrs** *	**Over 65yrs**	**Under 65yrs** 49	**Over 65yrs** 87
• Ethnicity of those attending	**Māori** 4	**Non-Māori** 84	**Māori** 6	**Non-Māori** 130
• Additional Family/Whànau or support person attending	45		74	
Total number of participants to Healthy Hearts (including family)	133		210	
PROGRAMME OUTCOMES on completion				
• Participants who report increased knowledge of their cardiovascular disease	99%		99%	
• Participants who report increased confidence to recognise and respond to their symptoms (manage their condition)	98%		99%	
PATIENT SELF-REPORTED FOLLOW-UP OUTCOMES over this reporting period (average 55% response rate)				
• Reported taking medication as prescribed (adherence)	97% *(Nationally 38%-46% do not collect medications after a major cardiac event. Highest rates among Māori. Reference: Atlas of Healthcare)*		94%	
• Presented to Emergency Department (ED) for cardiac related symptoms	9% *(Nationally evidence suggests there is a 40-50% reoccurrence rate i.e. presenting to ED with symptoms)*		0%	
• Reported heart healthy eating habits/improved eating habits	70%		98%	
• Reported adequate physical activity levels/increased levels	69%		91%	
Overall Uptake Rate (referral/attendance)				
• Percentage of people engaging in a rehabilitation choice	60% *(National average is 12-20%)*		51%* **Includes Marlborough uptake (26%)*	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

***Nelson Bays Primary Health have supported Marlborough Primary Health to develop a regional Cardiac Rehabilitation Service and has invited Marlborough patients to attend the Nelson-based service during the interim period.*

MAORI HEALTH ACTIVITIES

- 13 of the referrals identified as Māori
- 6 of the attendees identified as Māori

Nelson Bays Primary Health has been involved in a Primary Care-based Whakakotahi project, "Living longer, feeling better after a heart event" which looked at ways to improve medication adherence rates following a heart event. These rates are particularly low among Māori populations.

PERSONAL SUCCESS FEEDBACK

"Feel so much more confident in going forward and making good choices to keep healthy"

"Presented in a way that is easily processed and relevant"

"Excellent coverage of topics provided in a safe environment"

Community Diabetes Education Type 2 and Pre-diabetes

PURPOSE To empower people with Pre-Diabetes or Type 2 Diabetes to be actively engaged in managing their condition and reducing their risk of long-term complications.

OBJECTIVE

- Deliver sessions to meet the needs and availability of the patients e.g. afterhours, within General Practice, in a community venue close to where people live or work
- Build knowledge to decrease diabetes-related distress and better understand/manage diabetes (Type 2 or Pre) using healthy literacy techniques
- Build confidence to make life-long healthy choices
- Reduce the risk of long-term complications by improving HbA1c (blood glucose) levels

PROGRAMME OVERVIEW

- **Type 2 Diabetes Education** is delivered at various locations in the community and held mainly on Saturday's. Sessions are peer-reviewed by Diabetes Nurse Specialists at Nelson Marlborough Health and this primary secondary partnership works effectively
- **Reversing Pre-diabetes** is a one-off 2.5 hour session held in a community venue or after hours at a General Practice. Sessions are co-presented with the Green Prescription team
- All patients receive three postal questionnaires over a 12 month period to monitor outcomes
- Quality improvements are informed following a Plan, Do, Study, Act process

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Type 2 Diabetes Referrals				
• Numbers referred	55		106	
• Ethnicity	**Māori** 1	**Non-Māori** 54	**Māori** 14	**Non-Māori** 92
Type 2 Diabetes Education sessions				
• Number of sessions held after-hours	7		9	
• Total Number of sessions delivered	8		9	
• Number of patients attended	52		59	
• Gender of those attending	**Male** *	**Female** *	**Male** 26	**Female** 33
• Ethnicity of those attending	**Māori** 4	**Non-Māori** 48	**Māori** 4	**Non-Māori** 55
• Additional Family/Whānau or support person attending	17		20	
Total number of participants (including family)	69		79	

Community Diabetes Education Type 2 and Pre-diabetes

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
PROGRAMME OUTCOMES on completion				
• Patients who report increased knowledge of Diabetes	100%		99%	
• Patients who report increased confidence in self-management	97%		99%	
PATIENT SELF-REPORTED FOLLOW-UP OUTCOMES over this reporting period (average 53% response rate)				
• Reported an improved HbA1c blood test if tested/known	80%		92%	
• Reported moderate levels of diabetes distress	*		12%	
• Reported healthy eating habits/ improved eating habits	*		79%	
• Reported adequate physical activity levels/increased levels	*		85%	
Pre-Diabetes Education referrals				
• Referrals received	106		135	
• Ethnicity of referrals	**Māori** 10	**Non-Māori** 96	**Māori** 8	**Non-Māori** 127
Pre-Diabetes Education sessions				
• Number of sessions delivered in general practice	3		5	
• Total Number of sessions delivered (all after-hours)	12		13	
• Number of patients attended	82		95	
• Gender of those attending	**Male** 23	**Female** 59	**Male** 42	**Female** 53
• Ethnicity of those attending	**Māori** 4	**Non-Māori** 78	**Māori** 5	**Non-Māori** 90
• Additional Family/Whanau or support person attending	29		41	
Total number of participants (including family)	111		136	
PROGRAMME OUTCOMES on completion				
• Patients who report increased knowledge of Pre-Diabetes	100%		100%	

PROGRAMME MEASUREMENT	2016/2017	2017/2018
PATIENT SELF-REPORTED FOLLOW- UP OUTCOMES over this reporting period (average 52% response rate)		
• Reported an improved HbA1c blood test if tested/known	91%	79%
• Reported healthy eating habits/ improved eating habits	*	97%
• Reported adequate physical activity levels/increased levels	*	88%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Nelson Bays Primary Health staff promoting Diabetes week...

MAORI HEALTH ACTIVITIES

- 14 of the referrals identified as Māori
- 9 of the attendees identified as Māori

VULNERABLE POPULATIONS

- 2 Diabetes awareness sessions were delivered to 80 people identifying as Pacifica

PERSONAL SUCCESS FEEDBACK

"I can take control of my diabetes, scary as it is"

"Good overview at a good level for all to understand"

Community Falls Prevention

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

OBJECTIVE

- Deliver a 'one-off' Upright and Able education session to address community falls prevention referrals and support navigation into a community strength and balance group
- Build relationships and issue the 'Tick of Approval' to community group leaders who meet the ACC strength & balance criteria
- Support 'Approved' group leaders to meet and maintain criteria through training and development sessions

PROGRAMME OVERVIEW

Nelson Bays Primary Health has been chosen by ACC as the 'Lead Agency' for the Nelson Marlborough region to 'approve' community group leaders that meet ACC criteria.

The community falls prevention work links closely to the In-Home programme and the Fracture Liaison pathways, creating the whole of system joined up approach to primary, community and secondary services aimed at preventing falls and fractures.

The intended audience for community falls prevention are 65 years and over who are mobile, living independently and able to participate safely in group strength and balance classes.
The intention is to prevent falls by living stronger for longer and is part of a national initiative developed by ACC, Health Quality and Safety Commission and Ministry of Health.

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Referrals				
• Numbers referred	353		273	
• Ethnicity	**Māori** 1	**Non-Māori** 352	**Māori** 28	**Non-Māori** 245
Upright and Able Education session				
• Number of sessions delivered	20		16	
• Number of people attended	140		174	
Falls Awareness Promotions				
• Number of sessions delivered	8		9	
• Number of people attending	*		168	
Community Group Strength and Balance				
• Total number of groups approved	*		70	
• Number of kaupapa Māori groups approved	*		4	
• Number of training sessions provided to 'approved' group leaders	*		4	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

The intention is to prevent falls by living stronger for longer and is part of a national initiative...

Community Nutrition Service Primary Care Dietitians

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

OBJECTIVE

- Allocate dietitian clinic hours to every General Practice in the Nelson Bays region allowing eligible patients to access free dietitian support
- Build knowledge and confidence of our community, and our workforce through training and development in evidenced-based nutrition topics
- Deliver an evidenced-based, culturally appropriate programme to families which supports the national health target of 'Raising Healthy Kids'

SERVICE OVERVIEW

There are four components to the service:

1. Workforce development for primary health care workers including Nelson Bays Primary Health, Nelson Marlborough Health and Te Piki Oranga staff
2. Group self-management education for prevention and management of long term conditions
3. One-to-One Dietitian appointments within General Practice and other appropriate Primary Health Care Providers (e.g. Te Piki Oranga)
4. Deliver a group session to address childhood obesity prevention (in pre-schoolers) using the Toddler Better Health programme (or similar)

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Dietitian: 1:1 consultations (General Practice and Nelson Bays Primary Health)				
• Number of 1:1 individuals booked into clinic	942		917	
• Number attended	*		815	
• Ethnicity of those booked	**Māori** 11%	**Non-Māori** 89%	**Māori** 11%	**Non-Māori** 89%
Primary Care Dietitian: 1:1 clinics held at Te Piki Oranga				
• Number of clinics at Marae	6		7	
• Number attended	11		23	
	# Groups	**#People**	**# Groups**	**#People**
Type 2 Diabetes	7	55	8	71
Healthy Hearts	10	124	12	210
Pulmonary Rehab	6	110	3	60

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Child Obesity Prevention				
• Toddler Better Health; a 6-8 week group session	**# Groups** 3	**People** 30	**# Groups** 6	**People** 67
• Ethnicity of those attending	**Māori** *	**Non-Māori**	**Māori** 4	**Non-Māori** 63
Workforce Development				
• Number of education sessions	**# Sessions** 10	**People** 127	**# Sessions** 8	**People** 120
Programme Outcomes				
At Completion				
• Type 2 diabetes – percentage of participants have improved their knowledge			100%	99%
• Healthy Hearts – percentage of participants have improved their knowledge			99%	99%
• Eat Move Grow (formerly Toddler Better Health) – percentage of participants have improved their knowledge			100%	100%
12 Months After Completion				
• Type 2 diabetes – percentage who have sustained an improvement in their eating habits			88%	79%
• Healthy Hearts – percentage of people who have sustained an improvement in their eating habits			71%	98%
• Eat Move Grow (formerly Toddler Better Health)				
– % of children more physically active			66%	100%
– % of children spending less time on screens			33%	60%
– % of children eating more fruit and vegetables			66%	80%

**New measurement in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES:

- 11% of referrals identified as Māori
- Monthly clinic provided at Te Piki Oranga, Motueka. Seven clinics were held with 23 whānau attended. This is a 100% increase on 2016/17 year. Whānau are supported by a Pūkenga Atawhai to attend and participate in clinics. This has two-fold benefits i.e. workforce development for the Pūkenga Atawhai, combined with empowering whānau
- 6% of those attending a Toddler Better Health/ Eat Move Grow programme identified as Māori

OTHER VULNERABLE GROUPS:

- Primary Care Dietitians continue to support new migrants through individual clinic appointments for a range of conditions, including Type 2 diabetes, restricted eating in children and appropriate childhood growth

Community Nutrition Service Primary Care Dietitians

TARGETS

800 PATIENTS BOOKED INTO 1:1 DIETITIAN CONSULTATION CLINICS

This year 917 were booked into a clinic

20 GROUP EDUCATION SESSIONS

This year 23 sessions were held

8 CHILDHOOD OBESITY PREVENTION PROGRAMMES

This year we achieved 6, with 67 people

8 WORKFORCE DEVELOPMENT SESSIONS

This year we achieved 8

PARTICIPANT FEEDBACK

- A quarter of attendees at Healthy Hearts specifically mentioned that the dietary component was the most useful part of the programme

  "Learning what food to have in my kitchen"

- Twenty-three percent of Type 2 diabetes attendees specified the dietitian education was the most useful part of the session

  "Understanding diabetes and how food affects blood sugar was awesome"

  "Dietary section really good value - not "diet police", just pragmatic"

- Eat Move Grow feedback:

  "Both kids are starting to try more food and we are managing meal times better than before"

  "We are now eating together as a family"

  "I am now able to relax around meal times knowing my children will eat when they are hungry"

  "It has been nice to have a non-confrontational way to encourage my children to explore different foods. I have shown other family members, the idea of exploring foods using our different senses"

  "It was lovely to see my child more interested in physical activity and sharing this with his sibling"

Fracture Liaison Service Falls Prevention

PURPOSE To reduce the impact and incidence of hip fractures (fractured neck of femur) in older adults.

OBJECTIVE

- Identify potential osteoporotic fractures (fragility fractures) in Emergency Department and inform General Practice of potential risks
- Monitor fractured neck of femur (#NOF) rates
- Build awareness and knowledge of bone health, osteoporosis, fragility fractures and falls prevention through workforce development for health care workers
- Develop an evidence-based bone health electronic screening tool for primary care, to support early identification and management of osteoporosis and/or fragility fractures

PROGRAMME OVERVIEW

The Nelson Bays Primary Health Fracture Liaison service is a sustainable model that builds primary care pathways and supports early identification, treatment and management of osteoporotic fractures. The service connects primary, secondary and community services for a joined-up, whole of system approach.

Fracture Liaison Service Falls Prevention

12 MONTH OUTCOMES — KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Nelson Emergency Department data				
Number identified in Emergency Depart. (ED) with fragility fracture (potential osteoporotic fracture)	282		291+	
• Ethnicity	**Māori** 3	**Non-Māori** 279	**Māori** 4	**Non-Māori** 287
• Gender of those identified	**Male** 79	**Female** 203	**Male** 93	**Female** 198
Fractured Neck of Femur (#NOF)				
Number of hip fractures identified in Nelson	*		67 (dependent on Nelson Marlborough Health data)	
Workforce Development • Number of education sessions	**# Group** 12	**# People**	**# Group** 12	**# People** 135
• % increasing knowledge of topic	*		99.8%	
• % increasing confidence to address topic	*		99.8%	
Data from Bone Health screening tool				
• Number of General Practices using the screening tool	*		5 General Practices are piloting the screening tool	
• Number of screens completed	*		Trial completed July 2018	
• Screens identifying fracture risk due to osteoporosis	*		Trial completed July 2018	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

** A change in Nelson Marlborough Health Electronic Patient Management System impacted on the data collection from ED – so numbers are a best guess.*

MAORI HEALTH ACTIVITIES

- 4 people who had a potential osteoporotic fracture identified as Māori

It would appear, based on the data and evidence from the University of Otago review of Nelson Marlborough Māori Health Profile in 2011-2013, that Māori do not develop osteoporosis at the same rates as Non- Māori. A cause for celebration and learning as to why this is.

PROGRAMME OUTCOMES

- A successful trial of a newly developed electronic assessment tool for Falls and Fracture Risk Screening in primary care. has been completed this year. This has had challenges but will have better long term results and sustainability. The assessment tool will be rolled out into general practice soon
- Nelson Marlborough Health are still working on effective communication methods with a patient's General Practitioner when a fragility fracture is identified. A letter was originally introduced which came from Nelson Marlborough Health, signed by Dave Porter (Rheumatologist), but flaws with this process were identified and solutions are more challenging than expected. Currently the Fracture Liaison Service is working on a patient information resource which will be issued at the Emergency Department to encourage the patient to contact their General Practitioner (self-management). A follow up process is also being developed. The trial of this will begin in the near future

Green Prescription – (GRx)

PURPOSE Green Prescription is a process that guides patients to improved health, through better understanding of behaviours, physical activity and nutrition. This is achieved by empowering patients using effective self-management support aimed to build motivation and confidence to make sustainable healthy lifestyle choices.

OBJECTIVE

- Green Prescription programme options, aim to build knowledge and confidence for patients to be:
  - Physically active on a regular basis
  - Make healthier food choices
  - Able to initiate and sustain healthy lifestyle choices
- Monitor and evaluate patients who have engaged with the service
- Using a postal survey, monitor the long-term health outcomes of those who engaged with the service

PROGRAMME OVERVIEW

Green Prescription is a referral option which General Practitioners, their practice staff and other health providers can promote healthy lifestyles (e.g. weight management through physical activity, nutrition and mental wellness). A self-referral option is also available which is followed up by practice confirmation.

Rongoā Kākāriki GREEN PRESCRIPTION

Green Prescription programme options include:

- **QuickStart** – A 2.5 hour session designed to explore personal beliefs, motivation, behaviour change and goals: the aim being to remove barriers and build behaviour change skills delivered region wide
- **KickStart** – An 8-week programme that builds confidence and healthy habits through a cohesive group. The programme involves discussion and various physical activities. Delivered in partnership with aquatic and gym facilities in Nelson and Richmond
- **Condition specific self-management sessions** – such as Living with Type 2 Diabetes; Reversing Pre-Diabetes; Upright and Able for falls prevention; The Joint Programme (osteoarthritis self-management); or Healthy Hearts (cardiac rehabilitation)

Green Prescription – (GRx)

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Green Prescription Referrals				
• Numbers referred	1,802		1,733	
• Ethnicity	**Māori** 214	**Non-Māori** 1,588	**Māori** 211	**Non-Māori** 1,522
• Gender	**Male** 512	**Female** 1,290	**Male** 462	**Female** 1,271
KickStart (multi-week programme)				
• Number of people attending KickStart	478		552	
• Number of programmes delivered	12		13	
QuickStart (one-off education session)				
• Number of people attending QuickStart	52		252	
• Number of sessions delivered in-General Practice	1		2	
• Number of sessions delivered in the community	6		20	
• Total Number of sessions delivered	7		22	
Condition Specific self-management programme choice e.g. Type 2 Diabetes; Pre-Diabetes; Falls Prevention; The Joint Programme; Healthy Hearts				
• Number of people attending	977		710	
Outcomes				
At Completion				
• Percentage of participants that understand why they need to be active	100%		93%	
• Percentage of participants that made positive changes to food	63%		77%	
• Percentage of participants that feel supported to make and sustain lifestyle choices	100%		89%	
6 Months After Completion				
• Percentage of participants that are still regularly active	78%		79%	
• Percentage of participants that are still choosing healthier food options	97%		77%	
• Percentage of participants that report improved health outcome	88%		82%	

TARGETS

THE MINISTRY OF HEALTH TARGET WAS TO RECEIVE 1,841 REFERRALS PER ANNUM

We achieved 1,733

MAORI HEALTH ACTIVITIES:

- 12.2% of referrals identified as Māori

OTHER VULNERABLE GROUPS:

- Green Prescription co-delivered two lifestyle/ pre-diabetes education sessions to Pacific Island people, with over 80 people attending

NATIONAL INITIATIVES:

- **Green Prescription Steering Group** – Nelson Bays Primary Health has been extremely active in the formation and direction of a provider led steering group. Nationally, Green Prescription was devolved from the Ministry of Health to District Health Boards in late 2017. This ran the risk of the service fracturing and losing its national identity. The steering group membership includes District Health Boards; the Ministry of Health and seven Green Prescription provider representatives
- **2018 National Green Prescription Conference** – Nelson Bays Primary Health was awarded hosting rights for the first ever National Green Prescription Conference to be held early July 2018 in Nelson

PERSONAL SUCCESS STORY

"I was referred by my doctor due to high stress and Type 2 Diabetes. I now swim twice a week and bike once a week and eat reduced portions. I finally feel like I have some control."

"I found Green Prescription to be informative and enjoyable. I've changed my eating habits and joined a regular walking group. I definitely feel fitter and have lost a little weight too."

"I came because my friend asked me to come with her – I am really glad she did as I'm now feeling better, fitter and stronger."

"I thought all I needed was cheaper gym fees.... But what I got was worth so much more. I learned a lot about staying well and feeling like I can manage my pre-diabetes."

The Joint Programme Osteoarthritis Self-Management

PURPOSE To improve the quality of life by reducing pain for people living with osteoarthritis.

OBJECTIVE

- Build knowledge about osteoarthritis and pain management using health literacy skills and resources
- Build confidence of those attending to manage osteoarthritis symptoms
- Build self-management skills to reduce weight and increase physical activity levels
- Build an understanding of joint replacement services and criteria to access

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 regularly as prescribed

The session was developed by the Rheumatology Nurse Specialist who continues to provide clinical supervision to the staff delivering the session. The session has been peer reviewed by Nelson Bays Primary Health pain specialist, Nelson Marlborough Health's hip and knee replacement team, Orthopaedic Specialists and Community Physiotherapist. Delivery of this session is supported by the Green Prescription team.

TARGETS

DELIVER 8 SESSIONS THROUGH-OUT THE NELSON BAYS REGION INCLUDING TO RURAL AND REMOTE COMMUNITIES

Achieved 12

PARTICIPANT FEEDBACK

"My hip is so much better and I am now swimming daily"

"I now understand how and why I need to take my paracetamol, and it really does keep my pain under control and enables me to do the things I want to do"

PROGRAMME DETAIL	2016/2017		2017/2018	
Referrals				
Numbers referred	177		216	
• Ethnicity of referrals	**Māori** 1	**Non-Māori** 176	**Māori** 5	**Non-Māori** 211
• Gender of referrals	**Male** 32	**Female** 145	**Male** 49	**Female** 167
Programme Delivery				
The Joint Programme attendance				
• Ethnicity of attendance	**Māori** 0	**Non-Māori** 117	**Māori** 5	**Non-Māori** 153
• Gender of attendance	**Male** *	**Female** *	**Male** 34	**Female** 124
• Sessions delivered in rural or remote locations	6		5	
• Total Number of sessions delivered	8		12	
• Total Number of people attended	117		158	
Participant evaluation at completion of session				
Programme Outcomes	**2016/17**		**2017/18**	
• Percentage of participants that increased their knowledge of Osteoarthritis	99%		96%	
• Percentage of participants that increased their confidence in managing their Osteoarthritis	93%		95%	
6 Months After Completing the session				
• Percentage of participants who are managing their pain better	73%		78%	
• Percentage of participants who have increased their physical activity levels	33%		53%	
• Percentage of participants who have improved their eating habits	57%		60%	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 100% attendance rate by Māori referred (5 referred / 5 attended)
- Worked in partnership with Te Piki Oranga staff at Te Āwhina Marae and the Instructors of Te Oranga Pai to deliver a session in Motueka

Interpreter Service

PURPOSE To fund an interpreter service for primary care that supports patient understanding of their health consultation.

OBJECTIVE

- Provide an interpreter service that addresses the various communication needs of our population who do not speak or understand English
- Is culturally appropriate and offers either male or female interpreters
- Is a quality service
- Supports newly arriving quota refugees to understand and access the right health service at the right time

SERVICE OVERVIEW

Nelson Bays Primary Health contracts various providers, so general practice has a service to best meet the patient's need and the health service needs, while maintaining efficiencies and patient confidentiality.

The interpreter service providers are; Interpreting New Zealand (qualified interpreters via telephone or video); Language Line (telephone only) local District Health Board face to face interpreters and Red Cross Refugee Services Case Workers for new quota refugees.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

INTERPRETERS	2016/2017	2017/2018
Quota refugee (Red Cross) interpreter sessions	*	410
Face to Face local interpreter sessions	*	519
Interpreting New Zealand telephone/video sessions	*	91
Language line telephone sessions	*	17
Total Interpreter sessions funded	*	**1,037**
Refugee Orientation programme		
Multi week education programme facilitated by Red Cross Refugee Services to support newly arriving quota refugees. The Health module as part of this programme includes information on accessing health services including medicines, Emergency Department, After-hours and General Practice. It also includes sections on healthy eating/lifestyle, mental health, smoking cessation, maternity and oral health		
Quota refugee intake	90	127
Family reunification refugee intake	*	25
Refugee orientation programmes delivered	4	8
Refugee Healthy Living Programme		
Education programme to support former refugees adopt a healthy lifestyle and addresses increasing rates of obesity and type 2 diabetes in this population		
Number of families participating in programme	10	7

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Mental Health

Gateway Health Assessment Service

PURPOSE To ensure every child/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/young person's needs, and ensures they get access to the right health and education services to address their needs.

OBJECTIVE

- Nelson Bays Primary Health, Nelson Marlborough Health, Oranga Tamariki and the Ministry of Education work together to identify and respond to children and young people's health and education needs
- To provide a platform for Health, Education and Social Services to assess the needs of each client
- Work through the recommendations of the Interagency Service Agreement and gather feedback from the client/family (via the Social Worker as necessary)

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

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

GATEWAY	2016/2017	2017/2018
Number of referrals from Oranga Tamariki received	58	55
Number of Health Assessments undertaken	48	64
Number of inter-service panel meetings held	38	65
Gaps identified	Low Oranga Tamariki referrals	• Low referral numbers from Oranga Tamariki • Slowness of Gateway Health Assessments • Slowness of Ministry of Health reports being returned by post
Strategies implemented to reduce any gaps identified	Rack card developed	• Liaison with Oranga Tamariki on regular basis • Reminders to Paediatrics regarding children's reports

MAORI HEALTH ACTIVITIES

- 13 of the referrals identified as Māori

VULNERABLE POPULATION

- Gateway Assessment focuses only on Vulnerable children who are in Oranga Tamariki care or have care and protection issues

ORANGA TAMARIKI
Ministry for Vulnerable Children

Oranga Tamariki aims to receive an assessment that helps build a complete picture of a child/ young person's needs

Mental Health Services To Children in Care

PURPOSE To facilitate and coordinate the delivery of appropriate mental health services to meet mental health needs (behavioural and/or emotional) for children and young people in the care of Oranga Tamariki (previously Child, Youth and Family) and/or via a Gateway Assessment. The service is for those 18 years and under.

OBJECTIVE

- To facilitate and coordinate the delivery of mental health services to children
- Encourage the use of the Mental Health Packages of Care and ensure access to a Mental Health Package of Care within appropriate timeframes

PROGRAMME OVERVIEW

Nelson Bays Primary Health ensures a seamless service delivery of the mental health packages of care to children and young people. The service is made up of the following components:

- Participation at the Gateway Assessment panel meeting in Nelson
- Undertaking service planning across the district
- Coordinating the delivery of Oranga Tamariki endorsed interventions in Nelson
- Liaison with other relevant services and practitioners – Ministry of Health, Oranga Tamariki, Child and Adolescent Mental Health Service and Strengthening Families

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

MENTAL HEALTH SERVICES – CHILDREN IN CARE	2016/2017	2017/2018
Number of referrals to this service	*	19
Number of Packages of Care completed (clients can have more than 1 Package of Care)	*	21
Average timeframe of referral to Packages of Care (number of days)	*	18

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 7 children referred identified as Māori

VULNERABLE POPULATION

- 2 children referred identified as Asian

Persistent Non-Malignant Pain Programme

PURPOSE To enable clients to self-manage their persistent pain more effectively.

OBJECTIVE

To provide a specialist evidenced-based Persistent Non-Malignant Pain assessment and management service, which aims to have a positive effect on the client and their family, by reducing prevalence and effects of persistent pain. The service aims to:

- Increase the client's overall physical activity participation and build self-confidence
- Minimise the emotional distress as a result of living with persistent pain
- Reduce reliance on medications (including Opioids) and Emergency Department presentations

PROGRAMME OVERVIEW

The service is delivered by a multi-disciplinary specialist team, providing individual and group pain management interventions using a holistic model. Given the average duration of clients' pain is 5 years, two key questions are asked:

- Why is the client presenting in this way at this time?
- What can be done to reduce the client's distress and disability?

As a result of this service intervention, clients have experienced improvement in their coping skills for physical and emotional pain

Persistent Non-Malignant Pain Programme

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
• Number of referrals received	*	275
• Number of Māori participants	13	22
• Number of groups completed	2	1
Improvements after attending service		
• Clients' improved level of workability	*	8%
• Clients' enhanced ability to undertake activities in and around the home	*	18%
• Clients' increased ability to cope with pain without medications	*	14%
• Clients' reduction in opioid use	*	16%
• Number of clients engaged with the clinical psychologist	*	56
• Visual Analogue Scale	9%	15%
• Pain Disability Index	13%	18%
• Self Confidence Scale	22%	19%
Depression, Anxiety and Stress Scales		
• Depression • Anxiety • Stress	15% 7% 11%	1% 5% 5%
Functional Abilities Confidence Scale	14%	8%

**New measurement to Nelson Bays Primary Health in quarter 3 2017/18 and previous financial year's data not available.*

As a result of this service intervention, clients have experienced:

- Improvement in their coping skills for physical and emotional pain
- An increase in their ability to cope without medications and have reduced opioid use. Only modest improvements are seen on Depression, Anxiety and Stress Scales assessments; however, it should be noted that these measures are not specific for depression, anxiety and stress specifically related to pain

From 1 January 2018, Persistent Non-Malignant Pain has requested consent from clients to complete the psychometric measures 6 months' post intervention. Psychometric packs are now being sent to clients who completed intervention in January 2018. The 6-month follow-up results will be available for 2018/19 Quarter 1 reporting.

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 the primary care mental health practitioners is to ensure that individuals return to their full level of functioning by identifying and subsequently managing a mental health problem.

OBJECTIVE

- To improve coping strategies of people with mild to moderate Mental Health challenges
- To address referrals within a timely manner

PROGRAMME OVERVIEW

The ***Primary Mental Health Initiative Service*** is provided by sub-contracted providers across the Nelson Tasman region. The providers are made up of Psychologists, Counsellors and Psychotherapists who provide between 3 – 6 sessions (depending on the clinician). Referrals are available via General Practice or Māori Health Provider. This service is available to all age groups.

The ***Brief Intervention Service*** accepts referrals from General Practice or Māori Health Provider for clients aged 16 years and over. This service is staffed by four clinicians. The clinicians are trained in counselling and are also Registered Nurses.

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring severity in depression. It is a measure that is used by General Practices and Sub-contractors both in the Primary Mental Health initiative and in the Brief Intervention Service. This scoring is completed with a patient for their initial visit with the General Practitioner or Practice Nurse and again by their selected therapist at their final appointment. This provides a means to clinically evaluate any improvement in outcome.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

SERVICE	2016/2017	2017/2018
Primary Mental Health Initiative		
Referrals	1,767	2,421
Average drop of PHQ-9 scores from beginning of treatment to end of treatment	*	6.4
Time on Primary Mental Health Initiative Service waitlist	*	One week
Brief Intervention Service		
Referrals	938	944
Average drop of PHQ9 scores from beginning of treatment to end of treatment	*	8.0
Time on Brief Intervention Service waitlist (days)	*	28

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 122 of the referrals identified as Māori

Targeted Youth Health Service

PURPOSE To improve health outcomes for students enrolled in Alternative Education and the Teen Parent Unit by providing health assessments, supporting access to primary health care and other agencies when appropriate.

OBJECTIVE

- Provide a service which is responsive to young people – particularly rangatahi (young Māori), who suffer poorer health outcomes than their peers
- Provide a health assessment and support access to primary health care or relevant health services
- Ensure appropriate and timely referrals are made in order to improve youth health and reduce inequalities
- Support and encourage a return to mainstream education

PROGRAMME OVERVIEW

This service is primarily a mobile nursing service provided by a Registered Nurse who is skilled in youth health and youth development. An assessement is provided to all youth in the service. The assessment used is HEADSS which is an evidence-based tool for accessing 'need'. The focus of the service is on improving outcomes for individuals and reducing inequalities.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

TARGETED YOUTH HEALTH SERVICE	2016/2017	2017/2018	
Number of students enrolled	*	72	
Number of Young people who have had a HEADSS assessment	*	**Māori** 18	**Non-Māori** 19
Number of on-going referrals to other agencies	*	45	
Number of young people supported with oral health appointments	*	18	
Number of young people offered brief intervention for smoking cessation	*	**Māori** 8	**Non-Māori** 1
Number of young people referred for Mental Health treatment	*	**Māori** 2	**Non-Māori** 1

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 34 of the 72 students identified as Māori

ADDITIONAL STATISTICS AVAILABLE

Youth Alcohol and Other Drugs (AOD) Service

PURPOSE To provide Alcohol and Other Drugs and Mental Health Brief Intervention treatment, therapy, support and care coordination services, for young people in Nelson/Tasman on referral.

OBJECTIVE

To deliver a responsive Youth Alcohol and Other Drugs Brief Intervention service which is mobile and supports access to Alcohol and Other Drug and Mental Health Services for young people with mild – moderate alcohol and/or drug use.

PROGRAMME OVERVIEW

The service uses a youth participation model. The service is flexible and aligned to Nelson Bays Primary Health Mental Health Brief Intervention and Targeted Youth Health Services, Nelson Marlborough Health Addictions Services and Child and Adolescent Mental Health Services.

The service accepts referrals for children and young people with alcohol and other drug disorders with co-existing anxiety, depression, phobias and behavioural disorders if clinically appropriate. The service includes screening and the use of brief assessment tools such as the Strengths and Difficulties questionnaire or the Substance Use and Choices Scale. The expected maximum intervention is up to four sessions. These interventions are mainly in the form of one-on-one counselling sessions.

The service has strong connections to other providers of health services and links with school guidance counsellors for referrals.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017*	2017/2018
Number of young people referred to the Youth Alcohol and Other Drug Service	*	125
Number of clinics held	*	16
Number of group education sessions provided	*	48
Comparison of Substance Use and Choices Scale scores from start of treatment to end of treatment (percentage improvement)	*	65% reduction

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 28 of the 125 referrals identified as Māori

VULNERABLE POPULATION

- There was one former refugee family involved in the service

Services to Improve Access

Community Podiatry Service

PURPOSE To provide funding to an independent provider to deliver a specialist podiatry service that includes assessment and care of diabetes related foot problems that can lead to ulceration or potential amputation. The overall aim is to reduce the incidence of ulcerations and amputations within the Nelson Tasman population who have diabetes.

OBJECTIVE

- Deliver a podiatry service that:
  - Is a primary care service that prevents ulcerations (early intervention)
  - Addresses high risk diabetes foot symptoms, that could lead to ulceration or amputations
  - Is culturally appropriate and engages Māori and other vulnerable populations with diabetes
- Patient education opportunities are provided regarding good foot care and risk factor awareness as appropriate

SERVICE OVERVIEW

Nelson Bays Primary Health contracts a private podiatry service to deliver this contract across the Nelson Tasman region. The current provider is Nelson Bays (Mapua) Podiatry. This free service is accessed via a referral. An eligibility criterion ensures the service targets those that need it the most and have been identified as having diabetes related foot problems. The service is delivered via clinics, as listed below, although home visits are undertaken for special circumstances.

Marae podiatry clinics are delivered in partnership with Te Piki Oranga and are hugely valued by Maori who attend

TARGETS

NUMBER OF PATIENTS SEEN IS 2,540

This year the service achieved 2,443

PATIENT CONTACTS	2016/2017		2017/2018	
Total number of patient consultations (patients generally seen more than once)	2,484		2,443	
Consultations by ethnicity	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**
	312	2,172	359	2,084
Where were patients seen	**Clinics held**		**Clinics held**	
• Marae clinic (Whakatu and Te Awhina)	8		8	
• Hospital clinic	80		85	
• Mapua clinic	44		47	
• House calls	26		35	
• Golden Bay clinic	8		8	
• Other	0		1 (rest home)	
Number who Did Not Attend	*		295	
Number who declined	15		15	
Patient education opportunities provided:				
With support from Te Piki Oranga nurses	At all Marae clinics		Works in partnership with Te Piki Oranga staff at all Marae clinics	
Onward referrals were sent to:	**2016/2017**		**2017/2018**	
Orthotics	30		31	
Vascular surgeon	2		13	
District Nurse	*		50	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 359 of the people who accessed the service identified as Māori
- 78 of the people who accessed the service identified as Pasifika
- A Total of 437 high risk clients seen by the podiatrist service
- 8 podiatry clinics have been held this year at Te Piki Oranga in Te Āwhina Marae and Whakatu Marae
- Marae podiatry clinics are delivered in partnership with Te Piki Oranga and are hugely valued by Māori who attend. The Te Piki Oranga Nurses work on a triage system where they perform a foot check while offering toe nail cutting, diabetes care information and enquire about any issues. The Nurses then pass their client onto the Podiatrist to see, if the clients meet referral criteria (complicated foot problems)

Kaiatawhai Service

PURPOSE To improve access and reduce inequalities to Primary Health Care services for Māori and other vulnerable population groups.

OBJECTIVE

- To improve access and uptake of general practice health screenings
- To develop collaborative relationships within and across the primary health care community
- To provide a navigation and case management service through collaborative relationships across the health care service

PROGRAMME OVERVIEW

Nelson Bays Primary Health Kaiatawhai service works with General Practices and primary health care providers, to support the health and well-being of their patients/clients in the Nelson Tasman region. The service supports whānau enrolled with a General Practice to access health screenings that are available to them, such as: cardiovascular disease risk assessments, cervical smears, mammograms, vaccinations and diabetes annual reviews. The aim is to reduce inequities in health for Māori and other vulnerable populations.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Number of referrals	**323**	**276**
Number of health assessments completed	*	44
Number of patients referred to other primary health providers	*	61
Number of patients supported to be enrolled in General Practice	*	14

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Number of community organisations liaised with for the service	*	79
Referrals by ethnicity		
• European	*	151
• Māori	117	97
• Pasifika	13	14
• Asian	*	9
• Other/Unknown	*	5
Referrals by gender		
• Male	*	63
• Female	*	213
Referrals by age		
• 0-14	*	11
• 15-24	*	34
• 25-49	*	149
• 50-75	*	79
• 75+	*	3
Reason for referrals		
• Support to engage in Health Screening	*	184
• Access to Health Services	*	122
• Mental Health	*	11
• Education	*	26
• Other (Court, Housing New Zealand, Probation)	*	12
Of those referred		
• Unable to contact	*	11
• No longer in the area	*	3
• Declined	*	11
• Deceased	*	0

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 98 of the referrals identified as Māori compared to 117 in the previous year
- 8 people who identified as Māori were referred to Te Piki Oranga services
- 23 people who identified as Māori declined a referral to Te Piki Oranga services

OTHER VULNERABLE GROUPS

- 15 people who identified as Pasifika were referred compared to 13 in the previous year
- 10 people who identified as Pasifika were referred to the Pacific Trust
- 5 people who identified as Pasifika declined a referral to Te Piki Oranga services and 3 people declined a referral to the Pacific Trust

Of the referrals received, 14 patients identified as Asian, former refugees, Indian and unknown. The Kaiatawhai Service was able to support these referrals by linking them to Red Cross Refugee services, who supported health appointments with the help of Interpreters. It was agreed by all parties involved that Red Cross Refugee services were the better service as there was already an established relationship.

Of the referrals received, a high percentage were for cervical screening due to the cost barrier to go to General Practice. Vouchers provided by Nelson Bays Primary Health assisted 181 women to complete their smear. The high referral rate for smears were due to General Practice not being able to connect with patients via letters, phone calls or text messages.

Kaiatawhai Social Work Service

PURPOSE To improve access and reduce inequalities to Primary Health Care services for Māori and other vulnerable population groups by addressing the social determinants of health. This is a new service which commenced in January 2018.

OBJECTIVE

- To work with those referred to assist and empower them to:
  - Reduce isolation and /or other social issues
  - Identify unmet social determinants of health needs (e.g. housing, insulation, personal or family health, debt, violence, abuse or neglect)
- To develop collaborative relationships within and across the primary health care community
- To provide a navigation and case management service through collaborative relationships

PROGRAMME OVERVIEW

The Kaiatawhai Social Work Service provides a holistic social work assessment based on a popular Māori health model 'Te Whare Tapa Whā' along with a strengths based approach.
The aim is to work alongside patients to help them identify goals and improve health outcomes. The service also provides advocacy, navigation and links patients to community groups and/or Non-Government Organisations when they require on-going support.

PROGRAMME MEASUREMENT	2017/2018
Number of referrals	**55**
Number of Social Work assessments completed	20
Number of patients referred to other primary health providers/ Non-Government Organisations Community Groups	15
Number of patients supported to be enrolled in General Practice	5
Number of community organisations liaised with for the service	30
Referrals by ethnicity	
• European • Māori • Pasifika • Asian • Other/Unknown	28 20 4 3 0
Referrals by gender	
• Male • Females	23 32
Referrals by age	
• Under 15 • 15-24 • 25-49 • 50-75 • 75+	5 5 20 19 6
Reason for referrals	
	• Parenting • Work and Income • Mental Health • Alcohol and Drug Brief Intervention • Social Support • Housing • Safety Planning
Of those referred how many were;	
• Unable to contact • No longer in the area • Declined • Deceased	5 1 4 N/A

MAORI HEALTH ACTIVITIES

- 48% of the referrals identified as Māori
- 1 Māori client agreed to a referral to Te Piki Oranga

OTHER VULNERABLE GROUPS

- 7% of the referrals identified as Pasifika
- One former Refugee was referred and supported

Victory Community Centre

PURPOSE To provide funding via a sub-contract to improve access to primary health care services for Victory residents.

OBJECTIVE

- To enable Victory Community Centre to:
  - Reduce and/or remove barriers that prevent the Victory Community accessing primary health care services
  - Identify patient and whānau health and social service needs
  - Support whānau to navigate health and social services
  - Support to maintain good health and wellness through appropriate information and resources

PROGRAMME OVERVIEW

Nelson Bays Primary Health has a contract with Victory Community Centre to provide a health and social service coordination role to identify needs, gaps and barriers, then facilitate patient pathways to access primary health care services or other unmet health care needs. The service supports whānau to better understand their health condition or needs and how to access primary health care and wellness support services.

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Service Outcomes		
Number of clients accessing the service	341	456
The top five issues identified	*	1. Lack of affordable and emergency housing 2. Lack of support to Social Development services 3. Access to affordable medical and dental services 4. Affordable sexual health and contraception 5. Addiction issues
Percentage of referrals broken down by:		
Ethnicity: • European • Māori • Pasifika • Other	 * 30% 4% *	 30% 29% 2% 31%
Age: • 0-4 • 5-14 • 15-24 • 25-44 • 45-64 • 65+	 1% 1% 2% 7% 26% 62%	 11% 6% 8% 33% 28% 14%
Reason for clients accessing the service:		
• Health assessments • Mental Health • Social issues • Housing issues • Education • Other	81 13 8 2 10 *	313 50 36 18 35 4
Number of assessments completed	332	313
Number of unenrolled clients supported to enrol in General Practice	23	16
Number of clients supported to access other services	133	78
Number of former refugee families supported	*	11
Number of information sessions delivered	*	7

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Victory Community Centre

TARGETS

INCREASE NUMBER OF CLIENTS ACCESSING THE SERVICE TO 456

MAORI HEALTH ACTIVITIES

- 8 clients who identified as Māori were referred to Te Piki Oranga
- 23 clients who identified as Māori declined a Te Piki Oranga referral

SUPPORTING VULNERABLE GROUPS

Victory Community Centre are working with Whare Ora a Nelson Marlborough Health initiative to support high needs whānau to access a healthy homes referral for home insulation, fire alarm installation by Fire and Emergency New Zealand, home maintenance by the Menz Shed. Other agencies are also involved with this initiative.

Victory Community Centre are also:

- Supporting Te Piki Oranga to hold nurse clinics on a regular basis
- Working with volunteers who distribute wood, heaters and blankets to those in need within the community
- Hosting and involved with Stressbusters – a mental health introduction programme working with former refugees from Colombia.
- Working with the Nelson Tasman Pasifika Community Trust and strengthening relationships with Whakatu Marae
- Working closely with Victory Primary School who have 42% new New Zealander families, 30% Māori families and 28% other families enrolled at the school. These are significant statistics that provide vulnerable population within easy access, which Victory Community Centre staff engage with on a regular basis

General Practice

Care Plus

PURPOSE To provide additional funding for General Practices to allow better care for people who require high levels of care, or have high needs because of chronic (or long term) conditions or terminal illness. The aim that patients receive expanded, better-coordinated, lower-cost services from a range of health professionals.

OBJECTIVE

- To improve a patient's chronic care management by providing subsidised visits
- To reduce inequalities, by ensuring that the programme is reaching Māori and Pacific people
- To ensure that Care Plus and care plans are offered to all eligible patients

PROGRAMME OVERVIEW

Eligible patients are offered an initial comprehensive assessment, where their health needs are explored. An individual care plan is develop in partnership with the patient and realistic, achievable health and quality of life-related goals are set, 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 four appointments and each patient is able to utilise up to two 'packages of care' per year.

Quintile 5 represents people living in the most deprived 20 percent of small areas.

Care Plus aims to ensure that patients receive expanded, better-coordinated, lower-cost services from a range of health professionals

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Service Outcomes		
Number of patients Registered in Care Plus	6,900	7,357
Reason for registering on Care Plus		
• Expected to need "intensive clinical management" over the next 6 months of these:	*	7,357
– Has had six First Level Service primary care visits in the past six months		508
– Has had two acute non-surgical admissions in the past twelve months		210
– Has a terminal illness		97
– Has had two or more chronic conditions		7,104
– Is on active review for elective services		294
Number of reviews completed	16,860	17,618
Registrations broken down by ethnicity		
• Māori	11%	11%
• Pasifika	1%	1%
• Other	88%	88%
Registrations broken down by high needs		
• Māori, Pasifika, quintile 5	*	1,834
• Other	*	5,523
Average number of packages per registered Care Plus person	*	1.2
Average cost per registered Care Plus person	*	$199.50
Percentage of people with a care plan completed	*	100%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- We have seen the same number of Māori registered compared to the previous year

OTHER VULNERABLE GROUPS

- 334 pacific people registered in Care Plus this year
- 33% of those registered on Care Plus were identified as Māori, Pacific or quintile 5, which shows that the service is meeting the needs of the programme

Education

PURPOSE

Continuing Medical Education
To provide high quality Continuing Medical Education for Nelson Bays Primary Health-aligned General Practitioners, by funding and supporting a Royal New Zealand College of General Practitioners approved Education programme along with an Education Facilitator to maintain approved provider status.

Continuing Nurse Education
To provide the primary health care nursing workforce of Nelson Bays with quality ongoing professional development (education) relevant to the health needs of our population, ensuring up to date clinical excellence.

Quality Education
To up-skill the General Practice workforce in order to enhance the quality of leadership, systems and processes within General Practice, as required under Cornerstone Accreditation 'Aiming for Excellence' framework.

OBJECTIVE

Continuing Medical Education

- To ensure that Nelson Bays General Practitioners are kept up-to-date with current best practice and evidence-based Medicine through the Pegasus small-group model
- To ensure that Nelson Bays General Practitioners are skilled and knowledgeable to improve the health care of our region's population
- To ensure that identified learning needs are met

Continuing Nurse Education

- To ensure that the nursing workforce is skilled and knowledgeable and kept up to date with current best practice to improve the health care of this region's population
- To promote the use of self-reflection and portfolio development

Quality Education

- To deliver sessions that are required under the Cornerstone Accreditation 'Aiming for Excellence' framework to support General Practices meet accreditation standards

PROGRAMME OVERVIEW

Continuing Medical Education
Continual Professional Development is an on-going requirement for doctors as outlined by the Medical Council of New Zealand. To maintain a current practising certificate, doctors must meet recertification and continual professional development requirements. To support this professional development of the doctors who reside in Nelson Bays Primary Health General Practices, Nelson Bays Primary Health provides both Royal New Zealand College of General Practitioners endorsed Multidisciplinary team events and Pegasus Small-Group meetings on a monthly and bi-monthly cycle.

Continuing Nurse Education
Professional development is an on-going requirement for nurses as prescribed by the Health Practitioners Competence Assurance Act. 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. Nelson Bays Primary Health deliver local professional development opportunities for nurses to attend outside of their working hours.

Quality Education

Quality Education sessions are combined learning opportunities for the whole General Practice team. Nelson Bays Primary Health have some online training opportunities (e.g. Privacy Act) as well as face to face opportunities. Each General Practice is encouraged to register with Practice Managers and Administrators Association of New Zealand (PMAANZ). A PMAANZ affiliated General Practice is able to access funding up to $100 per year to support their administrative team. Nelson Bays Primary Health continues to facilitate bi-monthly Practice Manager Meetings to canvas administrative issues in General Practice and to provide Nelson Bays Primary Health support to troubleshoot these as they arise.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Pegasus small groups		
Number of Pegasus small groups completed	*	4
Average Number of Doctors engaged in the Pegasus model	*	51
Average rating of the overall quality of the meetings	*	4.5/5
Average rating of the quality of information provided (resource material)	*	4.4/5
Average rating of the importance and relevance of the content	*	4.5/5
Multidisciplinary sessions		
Number of Multidisciplinary sessions completed	*	6
Average quality rating of the sessions	*	4.3/5
Average rating of the quality of information provided (resource material)	*	4.1/5
Continuing Nurse Education Sessions		
Number of Continuing Nurse Education sessions completed	15	10
Nurse Personal development fund • Number of applications received • Number of application accepted	 * *	 27 26
Quality Education Sessions		
Number of Cornerstone Accredited sessions delivered	*	9
Percentage of General Practices who have achieved Accreditation	*	Foundation Accredited = 9.5% Cornerstone Accredited = 90.5%
Request to present at Education Sessions		
Number requested	*	9
Number accepted	*	2

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Palliative Care

PURPOSE To reduce the financial burden on the patient and/or their family in the terminal phase of their illness and support quality of life by providing continuity of care with the General Practice team.

OBJECTIVE

- To support patients to remain at home during the terminal phase of their illness
- To reduce the financial burden on the patient in their terminal phase of their illness
- For General Practice teams to provide a coordinated domiciliary palliative care service based on the needs of the individual and family/whānau

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 programme are allocated a package of care. There is a separate agreement for those enrolled in rural Motueka and Golden Bay practices.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Number accessing the service	289	379
Number of new Registrations	*	334
Referrals broken down by ethnicity		
• European	87%	85%
• Māori	5%	5%
• Pasifika	*	1%
• Other	9%	10%
Referrals broken down by gender		
• Male	47%	54%
• Female	53%	46%
Service provided		
• General Practitioner Home visit	29%	27%
• Nurse home visit	0%	0%
• General Practitioner Prescription	26%	25%
• General Practitioner Other	7%	8%
• Nurse prescription/other	1%	2%
• General Practitioner Consult	25%	28%
• Nurse consult	1%	1%
• Hospice visit	3%	3%
• Post death Visit	7%	6%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 5% of those who accessed the service identified as Māori

OTHER VULNERABLE GROUPS

- 1% of those who accessed the service identified as Pasifika

Primary Options For Care

PURPOSE To provide a service that reduces reliance on secondary care services by empowering primary care providers to provide more flexible and responsive services to patients closer to home, usually at their General Practice. The aim being to have a positive impact on health outcomes, and reduce hospital intervention.

OBJECTIVE

- To enable increased access to safe care for Nelson/Tasman patients with medical conditions which would previously have resulted in hospitalisation or the use of a Nelson Marlborough Health specialist service (e.g. outpatients)
- To reduce acute and elective demand at Nelson Hospital by providing services in primary care
- To improve service integration across the health system by working with the Health Pathways team on the development of relevant new and up to date pathways

PROGRAMME OVERVIEW

General Practices can provide 15 services under the Options for Care contract which would otherwise be delivered in the Hospital. Service providers can charge a co-payment on top of the Primary Options for Care funding for some but not all of the Primary options for care services. It is expected high needs patients will receive free services under this agreement.

Primary Options of Care is available to patients who live in the Nelson Marlborough area and are enrolled with a Nelson Bays Primary Health General Practice.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Services provided		
• IV therapies	485	537
• Therapeutic Venesections	249	301
• Spirometry – diagnostic	323	335
• Chronic Obstructive Pulmonary Disease Acute exacerbation management	16	23
• Insulin Initiation	13	30
• Management of Deep Vein Thrombosis	9	14
• Zolendronic Acid Infusions for metastases	4	13
• Ad Hoc Services	14	29
• Entonox (Pain)	58	84
• Polycythaemia Vera	9	10
Primary Options for Care Totals This represents the number of interventions completed in primary care, thus not requiring Emergency Department/ Hospital interventions/ admissions	1,180	1,376

continues over...

Primary Options For Care

continued

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Claims broken down by ethnicity	74%	78%
• European	6%	5%
• Māori	1%	0%
• Pasifika	1%	1%
• Asian	19%	15%
• Other/Unknown		
Claims by gender		
• Male	*	747
• Female	*	627
Percentage of Referrals by age		
• 0-4	*	1%
• 5-19	*	6%
• 20-34	*	12%
• 34-49	*	17%
• 50 -64	*	28%
• 65+	*	35%
Claims by location		
• Nelson	*	776
• Mapua	*	59
• Motueka	*	311
• Wakefield	*	75
• Golden Bay	*	142
• Renwick	*	11
Percentage of pathways that support Primary Options for Care	100%	100%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 5% of people who accessed the service identified as Māori

Skins Lesion Removal Service

PURPOSE To provide high quality skin lesion removal services within primary care, reduce waiting times for skin lesion removals and reduce the burden of non-melanoma skin cancer on secondary services.

OBJECTIVE

- To enable increased access to services closer to home
- To work in collaboration with Nelson Marlborough Health to reduce demand on secondary care

PROGRAMME OVERVIEW

The service includes a General Practice Advisor and Specialist Dermatologist who receive, triage and prioritise all referrals for skin lesion removal from general practice, then provide high level advice on management of all lesions referred.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Number of patients referred from General practice	1,714	1,766
Referrals broken down by ethnicity		
• European	90%	86%
• No specified	7%	8%
• Māori	2%	2%
Percentage of Referrals broken down by age		
• 0-4	1%	1%
• 5-14	1%	1%
• 15-24	2%	1%
• 25-44	7%	6%
• 45-64	26%	25%
• 65+	62%	65%
Triage destination of referrals received		
• Advice only	15%	10%
• Referred to General Practice	24%	27%
• General Practice with special interest	1%	0%
• Service to Secondary Care	57%	53%
• Declined	3%	4%
• Other	0%	1%
• Not yet triaged	0%	5%
Triage destination of referrals to secondary care		
• Dermatology Department	9%	9%
• Ear, Nose and Throat	22%	23%
• General Surgical	19%	21%
• Ophthalmology	*	1%
• Other	6%	0%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES

- 32 Māori were referred to the service this year compared to 42 last year

Smoking Cessation ABC in Primary Care

PURPOSE To reduce the prevalence of smoking in the Nelson Bays region and reduce harm caused by smoking, by supporting General Practices to provide better help for smokers to quit.

OBJECTIVE

- Offer free cessation advice to all smokers or refer them to cessation providers
- Actively promote the ABC approach to smoking cessation
- 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 advice and support to quit
- Ensure training is provided to the primary care workforce to gain knowledge and confidence to apply ABC effectively

PROGRAMME OVERVIEW

The 'Implementation of Smoking Cessation ABC in Primary Care' programme takes multiple approaches to achieve up-skilling General Practice in the ABC approach to smoking cessation, such as: embedding practice management systems; linking General Practice to external smoking cessation providers; linking with Nelson Marlborough Health-based secondary care Smokefree Coordinator; linking the ABC approach to the System Level Measures smoking indicator.

The Smoking Cessation programme consists of a brief intervention where health care workers provide brief assessment of a smoker's willingness to quit and a referral to an appropriate cessation programme if they are ready to quit. It also includes an intensive consultation to develop a quit plan, offering nicotine replacement therapy or pharmacological treatment as appropriate. Patients can access up to three free follow-up consultations, at one week, four weeks and three months from the initial consultation or quit date.

The ABC approach

A — Ask all people about their smoking status and document this

B — Provide Brief advice to stop smoking to all people who smoke, regardless of their desire or motivation to quit

C — Make an offer of, and refer to or provide, evidence based Cessation Treatment

Quintile 5 represents people living in the most deprived 20 percent of small areas.

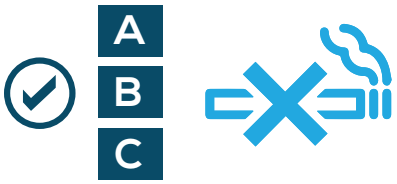
PROGRAMME MEASUREMENT	2016/2017	2017/2018
Percentage of patients identified as smokers	*	14%
Percentage of smokers offered brief advice	88.1%	87.8%
Number of Initial cessation consultations in practice	741	680
'In Practice' cessation consultations broken down by:		
Ethnicity		
• European	66%	71%
• Māori	22%	19%
• Pasifika	2%	2%
• Asian	2%	2%
• Other/Unknown	8%	6%
Gender		
• Male	52%	46%
• Female	49%	54%
Age		
• 15-24	6%	5%
• 25-49	55%	51%
• 50-75	37%	42%
• 75+	2%	2%
Treatment prescribed at initial cessation consultation		
• Patches	*	247
• Zyban	*	43
• No Treatment	*	83
• Gum	*	120
• Champix	*	246
• Lozenges	*	0
• Nortriptyline	*	2
• Other	*	5
First follow up		
• Number of service users	521	44
• Percentage who are smokefree	26%	23%
• Percentage who have reduced smoking behaviour	68%	71%
Second follow up		
• Number of service users	378	269
• Percentage who are smokefree	38%	35%
• Percentage who have reduced smoking behaviour	58%	61%
Third follow up		
• Number of service users	237	185
• Percentage who are smokefree	43%	31%
• Percentage who have reduced smoking behaviour	54%	63%
Follow up method		
• Phone	66%	65%
• In Practice group session	0%	1%
• In Practice consult	22%	22%
• Not stated	10%	12%
• Other	2%	13%
Percentage of smokers who have completed the programme and quit	47%	31%
Percentage of Practices who have completed the E-cigarette training	*	10%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Smoking Cessation ABC in Primary Care

TARGET (YEAR)

35% CESSATION RATE FOR SELF-REPORTED CESSATION



31% achieved

MAORI HEALTH ACTIVITIES

- 19% of people who accessed the service identified as Māori compared to 22% the previous year
- 16% of people who reported to be smokefree after 3 months identified as Māori

OTHER VULNERABLE GROUPS

- 2% of Pacific/Quintile 5 accessed this service which was the same percentage as the previous year
- 15% of Pacific/Quintile 5 reported to be smokefree after 3 months

The percentage of smokers who have completed the full "Smoking Cessation" programme and quit was 31%

Nursing Services

Community Respiratory Service

PURPOSE To provide a specialist Nurse led, community-based asthma and chronic obstructive pulmonary disease care and education service which includes assessment (using spirometry), treatment, medication advice and education in-line with current best practice.

OBJECTIVE

- Promote increased community awareness of asthma and chronic obstructive pulmonary disease through group education
- Support Primary Care providers to encourage self-management of their asthma/chronic obstructive pulmonary disease patients
- Link with community stakeholders to ensure constant messaging around respiratory conditions
- Support Nelson Asthma Society self-management and Pulmonary rehabilitation groups

SERVICE OVERVIEW

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

- Assessment, treatment, medication advice and education congruent with current best practice
- Work with General Practice to assist primary care staff to meet the needs of people with respiratory disease
- Working alongside Nelson Asthma Society to raise awareness of respiratory conditions
- Providing education and advice on asthma and chronic obstructive pulmonary disease and available services
- Linking clients with appropriate community-based support agencies, e.g. smoking cessation
- Scheduling post-discharge visits where required following asthma/chronic obstructive pulmonary disease exacerbations

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Referrals		
• Number of spirometry completed in primary care	298	334
• Range of Respiratory conditions presenting:		
– Percentage of clients with Asthma	*	3%
– Percentage of clients with chronic obstructive pulmonary disease	*	77%
– Percentage of clients with unknown respiratory conditions	*	21%

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Attendance				
• Number of referrals seen by Respiratory Nurse	37		49	
• Ethnicity of those seen	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**
	23	14	10	39
• Number of people who Did Not Attend	*		2	
• Where were clients seen				
	# Clinics	**# Attended**	**# Clinics**	**# Attended**
– Nelson Bays Primary Health	*	*	5	5
– Community clinic/home visit	*	*	2	2
• Age groups in percentages	*		0-5 years 25% 6-15 years 50% >45 years 25%	
• Number of self-management plans in place	*		5	
• Number of Pulmonary Rehabilitation groups	1		4 groups / 93 people	
• Ethnicity of Pulmonary Rehabilitation attendees	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**
	*	*	2	21
Workforce Development (Consultancy)				
• Number of education sessions provided	**# Sessions** *	**# Attended** *	**# Sessions** 7	**# Attended** 99
• Consultancy advice provided	*		6	
• Engagement with community services	*		Engaged with Nelson Asthma Society	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

MAORI HEALTH ACTIVITIES:

- 10 of the referrals identified as Māori

Director of Primary Care Nursing

PURPOSE The Director of Primary Care Nursing is a district wide position now into its second year. This position supports the strategic nursing direction of the regions two Primary Health Organisations – Marlborough Primary Health and Nelson Bays Primary Health, along with the Top of the South Health Alliance, which is an alliance between Nelson Marlborough Health, Nelson Bays Primary Health, Marlborough Primary Health and Te Piki Oranga.

OBJECTIVE

- Develop a well-supported nursing workforce that is agile, flexible and responsive to changing models of care
- Develop nursing capacity so nurses are working to the full extent of their scope
- Move nursing practice further into the community; to work across teams and to lead the provision of health care where appropriate
- Nursing is responsive to increasing access to health services for Māori and positively contributes to improving health outcomes for Māori and vulnerable people
- Nursing focuses on people self-managing their own care and disease prevention

PROGRAMME OVERVIEW

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

PERFORMANCE

The position has achieved the following key points during the year:

- Clinical leadership developed through Nelson Bays Primary Health's Practice Nurse Leaders Group
- Nurses working with practice teams to lead healthcare clinics
- Education offered to Registered Nurses and combined with their multidisciplinary team
- Mental Health and Addictions Primary Care Nurse Credentialing Programme offered
- Professional Development and Recognition Programme offered and assessed in primary care
- Mentorship and support provided to many Registered Nurses
- Nurse Practitioners integrated into the health care team

District Immunisation Facilitation Service

PURPOSE To increase immunisation coverage across the Nelson Marlborough eligible population. The aim, being to improve the health of all New Zealanders by protecting them from vaccine preventable diseases through an effective immunisation programme.

OBJECTIVE

- To provide up-to-date, accurate information to providers and the public about vaccines
- To ensure integrity of the cold-chain, through effective monitoring and audit
- To support providers to develop their recall systems and immunisation quality plans
- To proactively work across the region to reduce our immunisation decliner rates

Love them Protect them Immunise them!

SERVICE OVERVIEW

Nelson Bays Primary Health is the contract lead for this collaborative partnership between Nelson Marlborough Health Public Health Service and Marlborough Primary Health and maintains an effective and efficient link to primary care services. The key to this is good communication preferably face to face between immunisation facilitators and medical practitioners/practice nurses.

Immunisation facilitators also maintain effective linkages with other national immunisation services in particular National Immunisation Register administrators, Medical Officers of Health and Outreach Immunisation Services and includes regional immunisation advisors (currently employed by the Immunisation Advisory Centre) and other agencies or providers as appropriate.

The Immunisation Partnership Group provides the strategic leadership for increasing immunisation coverage in our region as well as sharing information, training/education, communication and other areas of common interest, where health gains can best be achieved through collaboration or cooperation.

Cold Chain is the process that ensures all vaccines are stored within the +2°C to +8°C temperature range at all times during storage or transport, from the point of manufacture through to the point they are administered to an individual. The process is to ensure immunisation providers safely store and transport vaccines and ensure all vaccines administrated are safe and effective. The integrity of the cold chain depends on three essential elements:

1. The people managing vaccine manufacture, storage and distribution and those managing the cold chain at the provider level
2. The systems and processes providers use to ensure they monitor the vaccine storage conditions, and actions taken if the vaccines are exposed to temperatures outside the required range
3. The equipment used for storing, transporting and monitoring vaccines from the time the vaccine is delivered to an immunisation provider to when the vaccine is administered to an individual.

District Immunisation Facilitation Service

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

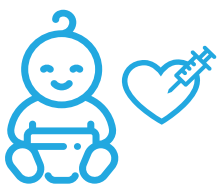
PROGRAMME MEASUREMENT	2016/2017	2017/2018
• Number of meetings held with Outreach Services	*	18
• Number of General Practices visited	*	112
• Number of newsletters published	*	5
• Education and training – number of sessions provided	*	17
• Number of participants attending	*	162
• Number of Cold Chain interventions required: – Nelson – Marlborough	 * *	 0 1
• Number of Cold Chain education sessions provided	*	5
Decliner Population Work		
• Number of strategies implemented	*	3
• Number of new programmes introduced	*	2
• Number of resources provided	*	3
• Difference in percentage of decliners over the year	*	0.6% increase

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

TARGETS

The Ministry of Health Target...

INCREASE 8 MONTH OLD IMMUNISATIONS TO 95%



Nelson Bays Primary Health achieved 91%

MAORI HEALTH ACTIVITIES

- Liaise with Te Piki Oranga to provide training and support for their nurses, this includes clinical assessments for immunisation authorisations
- Regular meetings with Te Piki Oranga to provide training, education and support towards clinical assessments for vaccination certificates and setting up flu clinics. Resources provided to Te Piki Oranga for promotion of Human Papilloma Virus (HPV) Immunisation
- Currently setting up programmes for community flu clinics to include Te Piki Oranga, Whakatū Mārae, Te Āwhina Marae, plus community centres in Nelson, Tahunanui and Motueka

OTHER VULNERABLE POPULATION ACTIVITIES

- Currently networking with Refugee support organisations and Pasifika Trust to support and reach other vulnerable population groups by inviting them to free flu clinics
- Focus this year for vulnerable populations has been immunising during pregnancy for influenza and Boostrix (for whooping cough)
- Liaising with midwives especially those that provide education and support to vulnerable mums and encouraging flu and Boostrix immunisations during pregnancy

Lactation Service

PURPOSE To provide Lactation Consultant Services and specialist breastfeeding support for Mums that meet referral criteria.

OBJECTIVE

- To support increased breastfeeding upon discharge from the maternity unit and up to 6 months post-natal
- To provide one on one consultations and advice to build the mother's confidence and knowledge
- To support workforce development towards increased confidence, knowledge and skills around breastfeeding

SERVICE OVERVIEW

Provides a Lactation Consultant on referral, across the Nelson Tasman region. The service provides education and lactation advice or support in the hospital, in primary care settings, or close to where Mums live.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Referrals				
• Number of referred	267		268	
• Ethnicity of new referrals	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**
	5%	95%	8%	92%
Attendance				
• Number of referrals seen	267		268 (100%)	
• Where were clients seen				
	# Clinics	**# People**	**# Clinics**	**# People**
– Hospital clinic	*	*	13**	22**
– Postnatal ward	*	*	N/A	14**
– Special Care Baby Unit	*	*	N/A	18**
– Community clinic	*	*	13**	16**
– Home visit	*		10**	
Waitlist				
• Average length of time on waitlist	1 week		1 week	
Workforce Development (Consultancy)				
• Number of education sessions	**Sessions**	**Attended**	**Sessions**	**Attended**
	7	75	10	57

PROGRAMME MEASUREMENT	2016/2017	2017/2018
Specialist areas/issues addressed		
• # Complexities addressed	N/A	11
• # Onward referrals	15 (40%)	9 (39%)
• Onward referrals to: – Paediatrician – General Practice – Dentist (lip/tongue ties) – Breast pumps	 8% 12% * 5%	 3% 15% 9% 2%
Outcomes		
• % Mums who were breastfeeding on discharge	66%	67%
• % Mums partially breastfeeding on discharge	27%	28%
• % Mums ceased to breastfeed on discharge	1%	3%

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*
***Data gathered from April 2018.*

MAORI HEALTH ACTIVITIES:

- It is encouraging to note that referrals for Māori women have increased from 5% in 2017 to 8% of all referrals to the service in 2018
- Nelson Bays Primary Health's Lactation Consultant is currently working towards closer collaboration with Te Piki Oranga's Lactation Consultant/Well Child Nurse to achieve higher breastfeeding rates in culturally appropriate ways

Telephone Nurse Triage Service Homecare Medical

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

OBJECTIVE

- Provision of quality telephone advice and assistance to participating GP patients when GP is unavailable (e.g. after-hours)
- Reduction of on-call commitments for participating GPs
- 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. Homecare Medical provides:

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

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

	2017		2018	
CALL ANALYSIS	Q1 JUL-SEP	Q2 OCT-DEC	Q3 JAN-MAR	Q4 APR-JUN
Total calls	1,753	1,685	1,272	888
Handover to on-call GP	292	324	337	305
Handover to after-hours primary care	133	131	98	55
Handover to emergency department	52	36	51	28
Handover to ambulance	76	76	59	59
Handover to non-health service	29	36	40	1
Other outcomes, exercise self-care and contact GP next day	285	302	244	211
Number of admin/practice information calls	886	780	443	229

Specialist Services

Infectious Diseases Service

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

OBJECTIVE

- Access to specialist input is provided within a timely manner
- Improve systems by:
  - Antibiotic stewardship – monitor the local infectious disease epidemiology and guide colleagues to prescribe rational and cost-effective antimicrobial for primary and secondary-care patients
  - Infection prevention and control - guide primary and secondary care services and colleagues to prevent acquisition and spread of infectious organisms
  - Microbiology laboratory - optimise 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
- Workforce Development
  - Education and collegial linkages – ensure a healthy and informed workforce and maintain connections with national and international colleagues and activities
- Complete research - 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.

SERVICE OVERVIEW

The Infectious Diseases Specialist provides a service across the Nelson Marlborough region that encompasses clients within both primary and community settings for better health outcomes. This role includes an emphasis on education and training to increase knowledge and provide appropriate resources for the overall reduction of infections and reduce the reliance on antibiotics if they are not required.

The Infectious Diseases Specialist service aims to reduce the incidence and optimise the treatment of infectious diseases and antibiotic-resistant organisms in Nelson and Marlborough

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017			2017/2018		
• Number of referrals	1,083			1,392		
• Ethnicity of new referrals	**Māori**	**Non-Māori**		**Māori**	**Non-Māori**	
	7	119		8	131	
• Patient waiting time from referral to first contact (compared to national target)	< 120 days			< 120 days		
• Breakdown of where patients seen: Virtual, clinic, hospital, other	**Virtual**	**Clinic**	**Hospital**	**Virtual**	**Clinic**	**Hospital**
	355	104	31	416	75	32
Workforce Development						
• Number of Teaching presentations	32			8		
• Number of audits in Nelson/ Marlborough	10			2		

TARGETS

WAITING TIMES LESS THAN 120 DAYS

All patients seen in less than 120 days

DID NOT ATTENDS LESS THAN 5%

TEACHING PRESENTATIONS MORE THAN 10 PER YEAR

8 Delivered

MAORI HEALTH ACTIVITIES

- 8 people referred identified as Māori

OTHER VULNERABLE GROUPS

- 3 people referred identified as Pasifika

Rheumatology Specialist Service

PURPOSE To provide a community-based Rheumatology Specialist model of care for the management of people with complex inflammatory/rheumatoid conditions. To also 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
- Achieves a timely follow up service by addressing the follow-up appointment wait-list
- Maintains robust staffing levels of clinicians providing regular clinics

SERVICE OVERVIEW

Nelson Bays Primary Health have been contracted to provide a General Practitioner with Special Interest orientated Specialist Rheumatology service for the region. Nelson Bays Primary Health employ a specialist Rheumatologist and specialist nursing staff to run the service across Nelson Marlborough. This service is free to all patients.

The service has undergone a number of changes this year creating challenges, but is now adequately staffed with a satisfactory number of General Practitioners involved as General Practitioners with Special Interest along with a locum Rheumatologist to provide back up as required. There is currently a significant number of patients on the follow-up wait-list, but a Rheumatologist review is underway to see who can be cared for by their own General Practitioner if support is provided by specialist staff.

PROGRAMME MEASUREMENT	2016/2017		2017/2018	
Client Outcomes	**Nelson**	**Marlborough**	**Nelson**	**Marlborough**
• Average time from referral to clinic for first specialist appointment	*	*	95 days	90 days
• Average timeframes for follow up appointments	*	*	18 months	18 months
• Number of clients seen:				
– First specialist appointments	*	*	366	147
– Follow up appointments	*	*	1,127	479
Service Outcomes				
• Compliance to meet Ministry targets:				
– Percentage for Nelson	80%		80%	
– Percentage for Marlborough	85%		100%	
• Number of General Practitioners Special Interest's within service:				
– Nelson	4		5	
– Marlborough	2		2	
Referrals	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**
• Total referral numbers (new)	60	306	38	475
• Age breakdown:				
– 10-19 years	*	*	2	8
– 20-30 years	*	*	2	27
– 30-40 years	*	*	13	58
– 40-50 years	*	*	9	83
– 50-59 years	*	*	3	107
– 60-69 years	*	*	3	114
– 70-79 years	*	*	4	70
– 80 + years	*	*	2	8
Treatments and Referrals				
• Biologics usage compared to National usage			182 total patients (3% higher than National figures)	
Number of referrals made to:				
– Pain service	*		8	
– Green Prescription	*		4	
– Brief Intervention service	*		2	
– Physiotherapy	*		10	
– Hand therapy	*		4	
– Dietitian	*		4	
– Orthotics service	*		0	

**New measurement to Nelson Bays Primary Health in 2017/18 and previous financial year's data not available.*

Rheumatology Specialist Service

TARGETS

PROVIDE 500 FIRST SPECIALIST APPOINTMENTS

Provided 513

PROVIDE 1,150 FOLLOW UP APPOINTMENTS

Provided 1,606

MAORI HEALTH ACTIVITIES:

- 136 of the referrals identified as Māori
- Presented at Te Tumu Whakaora and gathered support for how to improve engagement with Māori clients. Awareness that main reason for Māori referrals is related to Gout
- Fast-track referral system in place for Māori Health Providers, for a specialist nurse review: No referrals received this year
- Kaiatawhai Service was used to assist 10 clients to attend their clinic appointments

Dr Peter Jones, Specialist Rheumatologist
MB, ChB, B Med Sci, PhD, FRACP, PG Cert Acad Prac

Peter is from a New Zealand family but grew up in London and trained in clinical biochemistry, medicine and rheumatology in the UK. From 1995 he has worked in various clinical and academic roles across the North Island.

Peter joined the Ministry of Health in 2013 in a part-time role as a Chief Advisor, Community Health Service Improvement, where he has been the clinical lead for the System Level Measures quality improvement and integration framework, and the Mobility Action Programme.

Golden Bay Community Health

Golden Bay Community Health Overview

Golden Bay Community Health is a rural Integrated Health Facility providing extensive healthcare and Allied Health services to the community in Golden Bay.

The hospital wing has 24 residential care beds, a combination of rest-home and continuing care beds, in addition to this, there are 5 Flexi-beds that are used for acute patient admissions, palliative and/or respite care.

The District Nursing service offers extensive services in the home or place of residence, in addition to routine nursing services they provide palliative care for the greater community.

Our Well-Child/Public Health nursing service provides an excellent service to the community in Golden Bay.

The General Practice team continues to be busy, offering a wide range of primary care services which includes visiting specialists e.g. primary care dietitian clinics. In addition to General Practitioner/Practice Nurse services, Golden Bay Community Health also offer 24/7 emergency care to both the community and visitors to the area, with an on-site x-ray service and a highly skilled team of practitioners.

Aged Residential Care

PURPOSE To provide residential care services for residents assessed at either rest home level or hospital level care in Golden Bay.

OBJECTIVE

- To provide safe and holistic care in accordance with Aged Resident Care Standards
- To promote wellbeing and maximise health performance for individual residents
- To ensure staff are well trained and competent to provide high quality care to residents
- To maintain residential occupancy over 90%

SERVICE OVERVIEW

The Residential Service at Golden Bay Community Health has 24 dedicated beds and the capacity to flex between hospital and rest home level beds, depending on the needs of the community. The Residential Services support all aspects of resident care by a variety of professional staff including Health Care Assistants, Registered Nurses, General Practitioners and Allied Health professionals.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018		
To provide safe and holistic care in accordance with Aged Residential Care Standards				
• Achieve and maintain Aged Residential Care credentialing	Partial compliance	Compliant		
• Compare and benchmark national e.g. falls, medication error, pressure areas against Australian performance	*	**Falls** 43	**Pressure Areas** 2	**Medication Errors** 6
		Benchmarking against Australian standards indicates we compare favourably in the above areas		
Record number of complaints	*	3		
Record number of residents transferred to Nelson Marlborough Health or other facilities	*	No aged care residents transferred during this period		
To promote wellbeing and maximise health performance for individual residents				
• Quality of Life Benchmarking (QBP benchmarking) – quantitative • Satisfaction surveys (residents and whānau) – qualitative	*	• Achieved benchmarking for Quality of Life • Resident satisfaction survey completed June 2018. 22/24 completed. Summary: positive experience of care received. No significant areas of improvement identified		
To ensure staff are well trained and competence to provide high quality of care to the residents				
• Number of staff completed mandatory educational sessions – Registered Nurses – Health Care Assistants	 * *	 11/11 7/25		

continues over...

Aged Residential Care

continued

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018			
		(Next update is September 2018 to capture those not completed)			
• Numbers of Health Care Assistants who have completed Level 2,3,4 Health and Wellness Certificates	*	Level 2 = 1 completed Level 4= 1 completed			
• Level of uptake for post graduate education	*	3 Registered Nurses completed CTN701 Introduction to Clinical Teaching			
• Number of staff appraisals completed	*	**Registered Nurses**	**Health Care Assistants**		
		8/11	21/26		
		All outstanding appraisals are booked			
To maintain residential occupancy over 90%					
• Gender and ethnicity	**Māori**	**Non-Māori**	**Māori**	**Non-Māori**	
	*	*	1	23	
	Male	**Female**	**Male**	**Female**	
	*	*	5	19	
• Occupancy	416 vacant bed days	63 vacant bed days			
• Average length of stay	*	27 months			
• Number of respite days/year	270	348			
• Number of people on waiting list	*	14			

**New measurement to Nelson Bays Primary Health in 2017/2018 and previous financial year's data not available*

District Nursing Services

PURPOSE To provide home based nursing services to the eligible population of Golden Bay (who fulfil the admission criteria as established by Nelson Marlborough Health).

OBJECTIVE

- To provide nursing expertise to the residents of Golden Bay to support the provision of care in the home
- To provide specialised nursing service to palliative care patients and their whānau
- To provide specialised nursing service to Oncology patients and their whānau while coordinating care with secondary services
- Develop and maintain a healthy and skilled nursing workforce who are competent to meet the changing needs of the Golden Bay community

SERVICE OVERVIEW

A comprehensive nursing service that provides complex care to patients in their own environment.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	
To provide nursing expertise to residents of Golden Bay for the provision of care in the home			
• Total Number of patients enrolled into the service	119	197	
• Number of contacts	4,483	4,427	
• Ethnicity and gender of enrolled patients	*	**Māori** 5	**Non-Māori** 192
		Male 87	**Female** 110
To provide specialised nursing service to palliative care patients and their whānau			
• Number of palliative patients enrolled into service (as of July 2018)	*	6	
• Ethnicity of Palliative patients	*	**Māori** 1	**Non-Māori** 5
To provide specialised nursing service to Oncology patients and their whanau while coordinating care with secondary services			
• Number of Oncology patients enrolled (as of July 2018)	*	17	
Develop and maintain a healthy and skilled nursing workforce who are competent to meet the changing needs of the Golden Bay community			
• Number of post graduate studies	*	1 Post graduate paper in Oncology	
• Number of education sessions	*	44 education sessions held	
• Number attending national/ international conferences	*	1 attended National Palliative Care Conference	

**New measurement to Nelson Bays Primary Health in 2017/2018 and previous financial year's data not available*

Flexi Beds

PURPOSE To provide acute admission services for Golden Bay which includes medical and nursing intervention.

OBJECTIVE

- To provide an acute care service to adults in Golden Bay instead of being transferred to Nelson Hospital
- To provide an infusion service for patients who would otherwise require admission to Nelson Hospital
- To enhance and support the provision of chemotherapy services for Golden Bay
- To facilitate the provision of surgical services, close to home by supporting the Mobile Surgical Bus

SERVICE OVERVIEW

The Flexi beds are supported by 24 hours nursing/ medical service to provide appropriate inpatient care to the population of Golden Bay to minimise admissions to Nelson Marlborough Health.

PROGRAMME MEASUREMENT	2016/2017				2017/2018			
To provide an acute care service to adults in Golden Bay instead of being transferred to Nelson Hospital								
• Number of acute admissions (excludes respites)	343				314			
• Age, gender and ethnicity of admissions	**Male** 148		**Female** 195		**Male** 150		**Female** 164	
	Māori 7		**Non-Māori** 289		**Māori** 8		**Non-Māori** 305	
	<40	**41-60**	**61-80**	**>80**	**<40**	**41-60**	**61-80**	**>80**
	20	53	124	146	24	51	117	122
• Transfer of acute admissions to Nelson Hospital	24				28			
To provide an infusion service for patients who would otherwise require admission to Nelson Hospital								
• Number and type of infusion/ transfusion	**Iron**	**Pamidronate**	**Blood /blood products**		**Iron**	**Pamidronate**	**Blood /blood products**	
	9	13	21		22	8	7	
To develop and support the provision of chemotherapy services for the Bay								
• Number of chemotherapy/ biological administered	30				35			
• Number and type of infusion reactions	0				1			
To facilitate the provision of surgical services close to home by supporting the Mobile Surgical Bus								
• Number of patients	37				18 ** Two clinics cancelled – one due to Takaka Hill closure and one due to insufficient appropriate patients on surgical list			

Primary Care

PURPOSE To provide primary care services to the population of Golden Bay by highly skilled staff such as; General Practitioners, Nurse Practitioners, Practice Nurses and phlebotomy services.

OBJECTIVE

- To promote wellness and maximise health for the enrolled population of Golden Bay through the provision of health promotion and health interventions
- To expand service options to ensure greater choice for the community to receive care closer to home
- To maximise the use of primary care funded services e.g. Care Plus to ensure equity of access to health care services
- To develop and maintain a healthy and well educated workforce who are competent to meet the changing needs of the community
- To ensure the community are satisfied with the service provision at Golden Bay Community Health
- To continue to promote and deliver an integrated health care service

SERVICE OVERVIEW

The primary care service is divided into two sections. From Monday to Friday, full primary health care services are available. The second aspect of the service is a 24-hour emergency access. This includes a triage nurse and doctor available during working hours and 24 hours' access to emergency medical support.

HOW WELL DID WE DO? KEY PERFORMANCE INDICATORS

PROGRAMME MEASUREMENT	2016/2017	2017/2018	
To promote wellness and maximise health for the enrolled population of Golden Bay through the provision of health promotion and health interventions			
• System Level Measure targets – 8 month Immunisations (Target 95%) – Brief smoking (Target 90%) – Diabetes Annual Review (Target 90%)	 * * *	 80% 92% 73%	
• Number enrolled and engaged in Patient Portals e.g. Manage my Health (July 2018)	*	**Registered**	**Activated**
		1,194	1,040
• Waiting room times (average)	*	29 minutes	
• Current number of enrolled patients	*	4,980	
• Ethnicity of enrolled population	*	**Māori**	**Non-Māori**
		306	4,674
To expand service options to ensure greater choice for the community to receive care closer to home			
• New initiatives for care provided	• Triage	• Supported Youth Hub development • Implementation of Medical Assistant roles	

PROGRAMME MEASUREMENT	2016/2017	2017/2018
To maximise the use of primary care funded services e.g. care plus, to ensure equity of access to health care services		
• Percentage of Care Plus use (for those eligible)	*	100%
• Options for Care	*	100%
Develop a healthy and well educated workforce who are competent to meet the changing needs of the Golden Bay community		
• Number of nursing staff with specific training – PRIME – IMMS – Smear	 * * *	 7 6 5
• Number attending national/ international conferences	*	4
Community of Golden Bay are satisfied with the service provided at Golden Bay Community Health		
• Number of complaints/resolved	*	21/21
To continue to strengthen an integrated approach to health care provision		
• Specialist primary clinics provided on site	• Dietitian • Podiatrist • Ear Health Nurse • New Born Hearing Screen • Mole Map • Breast Screen Mobile Services • Palliative Nurse Practitioner • Alcohol and Drug Nurse Specialist	• Dietitian • Podiatrist • Ear Health Nurse • New Born Hearing Screen • Mole Map • Breast Screen Mobile Services • Palliative Nurse Practitioner • Alcohol and Drug Nurse Specialist
• Number of referrals for short term interventions (Mental Health)	*	144
To ensure 24 hour access to medical services		
• Number of afterhours GP consultations (includes weekend clinics)	*	1,063
• Number of PRIME callouts	32	29

**New measurement to Nelson Bays Primary Health in 2017/2018 and previous financial year's data not available*

Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

NELSON BAYS PRIMARY HEALTH TRUST

Financial Reports

for the year ended 30 June 2018

Nelson Bays Primary Health Trust

Summary Statement of Comprehensive Revenue and Expense

for the Year Ended 30 June 2018

	2018 $	2017 $
REVENUE		
Exchange		
Patient fees	737,478	755,785
Interest	123,171	85,718
Age Related care	1,432,309	1,298,664
Non-Exchange		
Hospital Funding	2,620,476	2,608,476
Management Services	871,160	862,681
Share of profit/(loss) from Joint Venture - Health Systems Solutions Limited	13,098	6,361
Share of profit/(loss) from Joint Venture - Medical and Injury Centre Limited	55,763	5,104
Primary Care Contract Services	23,699,141	23,190,991
Other	204,444	210,388
Total Revenue	**29,757,040**	**29,024,168**
LESS EXPENSES		
Accounting and Audit	23,207	27,274
Office & Organisation Expenses	1,475,297	1,474,855
Loss on sale of Investment	2,533	-
Board Expenses	137,613	130,815
Staffing Expenses	1,284,555	1,118,141
Primary Care Services	21,221,966	20,333,240
Other Costs	5,325,735	5,192,644
Total Operating Expenses	**29,470,906**	**28,276,969**
NET SURPLUS	**286,134**	**747,199**
Total comprehensive revenue and expense for the year	**286,134**	**747,199**

NOTE:	2018 $	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.	79,639	459,824
Share of profit/(loss) from Joint Venture and interest received	192,032	97,183
Remaining surplus	14,463	190,192
NET SURPLUS	**286,134**	**747,199**

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

Nelson Bays Primary Health Trust
Summary Statement of Changes in Equity
for the Year Ended 30 June 2018

	Committed Funding Reserve	Retained Earnings	Total Equity
Balance as at 1 July 2016	1,889,682	899,204	2,788,886
Total comprehensive income for the year	459,824	287,375	747,199
Balance at 30 June 2017	**2,349,506**	**1,186,579**	**3,536,085**
Balance as at 1 July 2017	2,349,506	1,186,579	3,536,085
Total comprehensive income for the year	79,639	206,495	286,134
Balance at 30 June 2018	**2,429,145**	**1,393,074**	**3,822,219**

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 2018

	2018 $	2017 $
CURRENT ASSETS		
Cash and cash equivalents	578,697	1,044,465
Investments	3,689,417	2,887,558
Receivables and Prepayments	1,156,108	1,074,202
Total Current Assets	**5,424,222**	**5,006,225**
CURRENT LIABILITIES		
Payables	1,188,238	1,206,180
Employee benefits	870,866	736,395
Total Current Liabilities	**2,059,104**	**1,942,575**
WORKING CAPITAL	**3,365,118**	**3,063,650**
NON-CURRENT ASSETS		
Plant, Property & Equipment	577,920	595,127
TERM LIABILITIES	**120,819**	**122,692**
NET ASSETS	**3,822,219**	**3,536,085**
Represented by:		
Committed Funding Reserve	2,429,145	2,349,506
Retained Earnings	1,393,074	1,186,579
EQUITY	**3,822,219**	**3,536,085**

17 September 2018

Trustee: John Hunter
Dated: 17/09/2018

Trustee: Sarah Green
Dated: 17/09/2018

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

Nelson Bays Primary Health Trust
Summary Statement of Cash Flows
for the Year Ended 30 June 2018

	2018 $	2017 $
Net cash flows from operating activities	463,295	1,228,002
Net cash flows from investing activities	(929,063)	(1,480,926)
Net increase / (decrease) in cash and cash equivalents	**(465,768)**	**(252,924)**
Cash and cash equivalents at beginning of period	1,044,465	1,297,389
Cash and cash equivalents at end of period	578,697	1,044,465

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

Nelson Bays Primary Health Trust
Notes to the Summary Financial Statements
for the Year Ended 30 June 2018

The summary financial statements for Nelson Bays Primary Health Trust for the year ended 30 June 2018 have been extracted from the full financial statements. The full financial statements were approved by the Board on 17 September 2018. 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 2018 financial statements. (2017: none)

The auditor BDO Wellington Audit Limited 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 Audit Limited

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 2018, 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 2018. We expressed an unmodified audit opinion on those financial statements in our report dated 17 September 2018.

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".

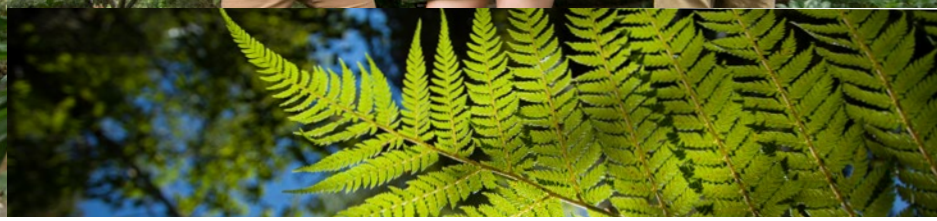
Other than in our capacity as auditor we have no relationship with, or interests in, Nelson Bays Primary Health Trust.

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 2018 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 Audit Limited

BDO Wellington Audit Limited
17 September 2018
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